CCME

2016 External Quality Review

SELECT HEALTH OF SOUTH CAROLINA

Submitted: November 16, 2016

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCO) to evaluate their compliance with state and federal regulations in accordance with Title 42 Code of Federal Regulations (CFR) 438.358. The purpose of this review is to determine the level of performance demonstrated by Select Health of South Carolina (Select Health) since the *2015 Annual Review*. This report contains a description of the process and the results of the *2016 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

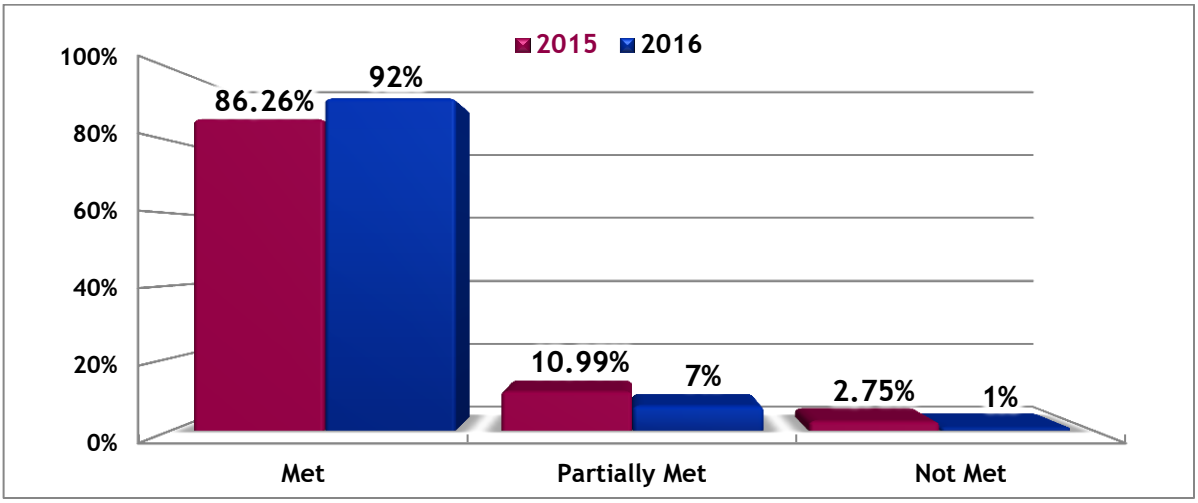
- determine if Select Health was in compliance with service delivery as mandated in the Managed Care Organization (MCO) contract with SCDHHS;
- evaluate the status of deficiencies identified during the 2015 Annual Review and any ongoing corrective action taken to remedy those deficiencies;
- provide feedback for potential areas of further improvement; and
- assure contracted health care services are actually being delivered and are of good quality.

The process used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of an MCO. The review includes a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects, and validation of performance improvement measures.

Overall Findings

The *2016 Annual EQR* shows that Select Health achieved a "Met" score in 92% of the standards reviewed, a "Partially Met" score in 7% of the standards reviewed, and a "Not Met" score in 1% of the standards reviewed. The following chart provides a comparison of Select Health's 2016 review results to the 2015 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review, as well as specific strengths, weaknesses, applicable quality improvement items, and recommendations can be found in the narrative of this report.

Administration:

Compliance and Program Integrity Plans as well as numerous policies define how Select Health educates employees and providers on fraud, waste, abuse, and the Fair Claims Act. Select Health monitors for evidence of non-compliance, and addresses identified issues. The Compliance Committee was previously a sub-committee of the Quality Assessment Performance Improvement Committee (QAPI). However, it is now an independent committee with a direct line of communication to the corporate compliance director.

The Information Systems Capability Assessment (ISCA) documentation and supporting materials confirm Select Health values the security, recoverability, and accuracy of all data collected. Additionally, a well-documented *Disaster Recovery Plan* has been tested and is in place.

Provider Services:

The *Credentials Program 2016* document and policies define the credentialing and recredentialing processes. Overall, the credentialing program is well-established with documents identified as needing updates. The credentialing/recredentialing files were in good order and contained appropriate information. The Credentialing Committee is chaired by Dr. Greg Barabell, Market Chief Medical Officer (CMO), and voting members of

the committee include the regional CMO, four Select Health medical directors, and three network providers with specialties in pediatrics and family practice. Select Health recognizes the need to have additional network providers on the committee and is pursuing providers with the specialties in orthopedic surgery and behavioral health.

Select Health has appropriate policies and processes in place for provider network evaluation. A few policies require updates and there were inconsistencies in some of the documents relating to the Provider Directory and appointment access standards.

The Telephone Provider Access Study conducted by CCME shows no improvement in the access members have to their PCP. Calls were successfully answered 39% of the time by personnel at the correct practice. When compared to last year's results of 39%, this year's study remained unchanged.

Member Services:

Select Health provides information to new members via the new member packet containing the *Member Handbook*, *Co-Payment Reference Guide*, *Notice of Privacy Practices*, and *Quick Start Guide*. In addition, attempts are made to contact new members by telephone to provide member orientation to the plan. The *Member Handbook* is written in simple language for ease of understanding. Some contractually-required information is absent and information regarding Advance Directives is very brief. The *Member Handbook* is currently being revised to include more comprehensive information on Advance Directives and include contractually-required information.

Select Health uses a certified vendor to conduct annual Member Satisfaction surveys. Response rates for the most recent Member Satisfaction surveys were only 23% (Child) and 20% (Adult) — lower than for the previous survey. CCME encourages Select Health to work with the vendor to develop and implement strategies to improve survey response rates.

Grievance requirements and processes were well-documented. Grievance file review, however, revealed several grievances for which Select Health did not meet timeliness requirements for resolution and notification. One file identifies a grievance containing possible clinical issues which was not reviewed by an appropriate grievance reviewer as defined in the *SCDHHS Contract* and Select Health policy.

Quality Improvement:

Select Health's *Quality Assessment and Performance Improvement 2016 Program Description* outlines Select Health's program for measuring and improving care and services received by members and their providers, along with objectives and goals for the program. The program description addresses development, implementation and

adherence assessment of clinical, preventive, and behavioral health practice guidelines. The Quality Assessment Performance Improvement Committee, chaired by the market president, oversees Select Health's Quality Improvement program activities.

Four Performance Improvement Projects were validated. One project received a validation score within the *Confidence* level, two were scored within the *Low Confidence* level, and one was scored within the *Not Credible* level. The four projects failed to meet the validation protocol requirements. Some corrective actions identified for the projects during the previous EQR were not implemented. The Healthcare Effectiveness Data and Information Set (HEDIS) measures met the protocol guidelines and were all considered fully compliant.

Utilization Management:

Select Health has program descriptions for the Integrated Utilization and Care Management Programs which are comprehensive and detail the functions for staff working in their respective areas. Dr. Burnham is the Regional Senior Medical Director and is responsible for the development and oversight of implementation of the utilization management program. Policies reviewed for this area mostly included correct timeframes and processes. One appeals policy and one letter template were the only exceptions that will require updating. The *Member Handbook* did not contain information on the emergency five day supply for prescriptions awaiting prior authorization or the program that allows for 90-day refill for some medications to treat specific conditions. Case Management files reflect excellent assessments, personalized goals, and continuation of case management services until goals are achieved.

Delegation:

Select Health delegates credentialing functions to multiple entities and some utilization management functions to NIA. Appropriate processes are in place for delegation initiation and oversight. Scores for the standards in the Delegation section of the review improved from 100 % "Not Met" for the previous EQR to 100 % "Met" for this review. All Select Health's delegates scored 100% compliance for the most recent annual oversight activities.

State Mandated Services:

Select Health provides all core benefits required by the *SCDHHS Contract* and encourages members to participate in recommended health screenings and services using a variety of methods, including mailings and telephonic reminders. Care gap reports are disseminated to providers, and alternate methods are available for providers to check for care gaps on individual members. Providers are routinely monitored and informed of their performance rating for compliance with immunization administration, and provision of

recommended preventive screenings and services. Only one deficiency from the previous external quality review was noted to remain uncorrected.

Table 1, Scoring Overview provides an overview of the findings of the current Annual Review as compared to the findings of the 2015 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2015	16	1	0	0	0	17
2016	33	0	0	0	0	33
Provider Services						
2015	64	3	2	0	0	69
2016	67	7	1	0	0	75
Member Services						
2015	32	4	0	0	0	36
2016	34	3	0	0	0	37
Quality Improvement						
2015	14	1	0	0	0	15
2016	14	0	1	0	0	15
Utilization						
2015	28	11	0	0	0	39
2016	34	4	0	0	0	38
Delegation						
2015	0	0	2	0	0	2
2016	2	0	0	0	0	2
State Mandated Services						
2015	3	0	1	0	0	4
2016	3	0	1	0	0	4

METHODOLOGY

The process used by CCME for EQR activities is based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP. This process focuses on the three federally-mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On 9/6/16, CCME sent notification to Select Health stating the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to provide Select Health an opportunity to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Select Health on 9/20/16 and reviewed in the offices of CCME (see Attachment 1). These items focus on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. A review of credentialing, grievance, utilization, case management, and appeal files was also conducted.

The second segment was an onsite review conducted on 10/18/16 and 10/19/16 at Select Health's office located in Charleston, SC. The onsite visit focused on areas not covered in the desk review or items needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Select Health's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Select Health and SCDHHS. Strengths, weaknesses, quality improvement plans and recommendations are identified, where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated. All results are recorded in the tabular spreadsheet (Attachment 4).

A. Administration

The Administration review focuses on the health plan's policies and procedures, staffing, information systems, compliance, and confidentiality. Select Health of South Carolina (Select Health) is a part of the AmeriHealth Caritas family of companies which administers benefits for SC Medicaid members under a contract with the South Carolina

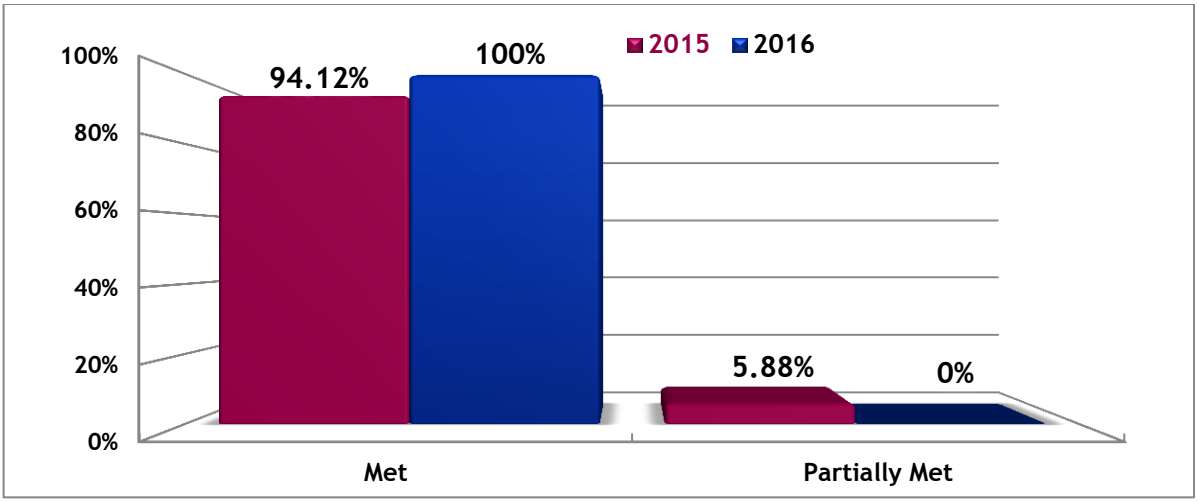
Department of Health and Human Services (SCDHHS). Rebecca Engelman is the Market President for Select Health and has responsibility for the day-to-day business activities. Policies and procedures are well-organized with an annual review clearly documented in all policies. Dr. Burnham, a board-certified family practitioner, is the Regional Senior Medical Director and Dr. Greg Barabell, a pediatrician, serves as the Medical Director for Select Health.

Deonys de Cárdenas is the Director of Agency Affairs/Compliance and serves as the Privacy Officer for Select Health. The Compliance and Program Integrity Plans are very thorough and meet contract requirements with one exception. It is recommended that Select Health add a statement to the *Compliance Plan* or a policy that includes the providers' responsibility to train staff on the False Claims Act as required in *Section 11.2.4* of the *SCDHHS Contract*. Members and providers are informed to report any suspicion of fraud or abuse via toll-free and anonymous fraud hotlines. The Compliance Committee was previously a sub-committee of the QAPI. It is now an independent committee with a direct line of communication to the Corporate Compliance Director. Compliance Committee members are inconsistently listed across several documents.

Select Health's claims payment times exceed contract requirements with processes in place to monitor completeness, timeliness, and accuracy. Select Health has implemented disaster recovery (DR) and business continuity plans for systems servicing the *SCDHHS MCO* contract. The plans are well-documented and incorporate a tiered recovery strategy for disaster recovery and business continuity. Select Health also performs annual DR and business continuity tests. The most recent results indicate the exercise(s) was completed successfully.

Select Health received "Met" scores for 100% of the standards in the Administration section.

Figure 2: Administration Findings



Strengths

- The Compliance Committee is now an independent committee with a direct line of communication among the committee, the local compliance director, and the corporate compliance officer.
- Select Health's process for emergency situations was recently tested during a period of mandatory evacuations. Executive staff indicated they were able to continue work remotely and there was no interruption in member services functions.
- Network and physical security best practices are used to secure Medicaid data and the appropriate measures are in place to log and monitor data security.

Weaknesses

- The membership list of the Compliance Committee found in the *QAPI Program Description*, the committee charter, and the Program Integrity description were not consistent.
- The *Compliance Plan* or associated policies do not include the requirement for Select Health to verify providers train staff on the Federal False Claims Act.

Recommendations

- Include in the *Compliance Plan* or a policy that Select Health informs providers about the responsibility to train staff on the Federal False Claims Act as required in *SCDHHS Contract, Section 11.2.4.*
- Confirm that an accurate and consistent list of Compliance Committee members is found in documents containing a membership list.

B. Provider Services

A review of Select Health's policies and procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines was conducted for Provider Services. Dr. Greg Barabell, market chief medical officer (CMO), chairs the Credentialing Committee and voting members include the regional CMO, four Select Health medical directors, and three network providers with the specialties of pediatrics and family practice. The Credentialing Committee meets on a monthly basis and reports to the Quality Assessment and Performance Improvement Committee. The Credentialing Committee chair votes only in the case of a tie and a quorum is met with over 50% of the voting members in attendance. A review of committee meeting minutes reflects a quorum was met at each meeting. Onsite discussion confirmed that Select Health is pursuing additional network provider membership for the Credentialing Committee with the specialties of orthopedic surgery and behavioral health. Issues relating to the Credentialing Committee are discussed in the "Weaknesses" section below.

The *Credentials Program 2016* document and policies define the credentialing and recredentialing processes. Updates are needed but, overall, the credentialing program is well-established. The credentialing/recredentialing files were in good order and contained appropriate information. A recommendation was made for one recredentialing file to ensure outreach is made to obtain updated documents/certificates for credentialing/recredentialing when the expiration date is within 30 days of receipt.

Network accessibility reports were received which showed that appropriate standards for measuring access were applied and, for the most part, Select Health has a solid network with access that exceeds contract requirements. A few issues with policies are discussed in the "Weaknesses" section below. Select Health measures appointment availability through analyzing questions on the annual CAHPS 5.0 survey and through monitoring ongoing grievances. The CAPHS survey for 2015 showed that getting needed care and getting care quickly (appointment access) had trended down from the previous year. Onsite discussion confirmed that Select Health is considering conducting an appointment access survey in 2017.

Provider Access and Availability Study

As part of the annual EQR process for Select Health, a provider access study was performed focusing on primary care providers (PCP). A list of current providers was provided to CCME by Select Health. A population of 2,714 unique PCPs was identified. A sample of 283 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

CCME conducted the Telephone Provider Access Study and determined calls were successfully answered 39% of the time (111/283) by personnel at the correct practice. This estimates between 36.4% and 41.9% for the entire population using a 95% confidence interval. When compared to last year's results of 39%, this year's study results remained unchanged.

Table 2: Provider Access and Availability Study

	Sample Size	Answer Rate	Fisher's exact p-value
2015 Review	320	39%	.93
2016 Review	283	39%	

For those not answered successfully (n=172 calls), 75 (44%) were unsuccessful due to the provider not being at the listed office or phone number. Of the 111 successful calls, 89 (80%) of the providers indicated that they accept Select Health. And of the 89 that accept Select Health, 63 (71%) responded they are accepting new Medicaid patients.

Regarding a screening process for new patients, 36 (56%) of the 64 responding providers indicated that an application or prescreen was necessary. Of those 36, 9 (25%) indicated that an application must be filled out, 12 (33%) require a review a medical records before accepting a new patient, and 5 (14%) required both. When asked about the next available routine appointment, 52 (80%) of the 65 responses met contact requirements.

The chart below shows that 89 percent of the standards in Provider Services received a "Met" score.

Figure 3: Provider Services Findings

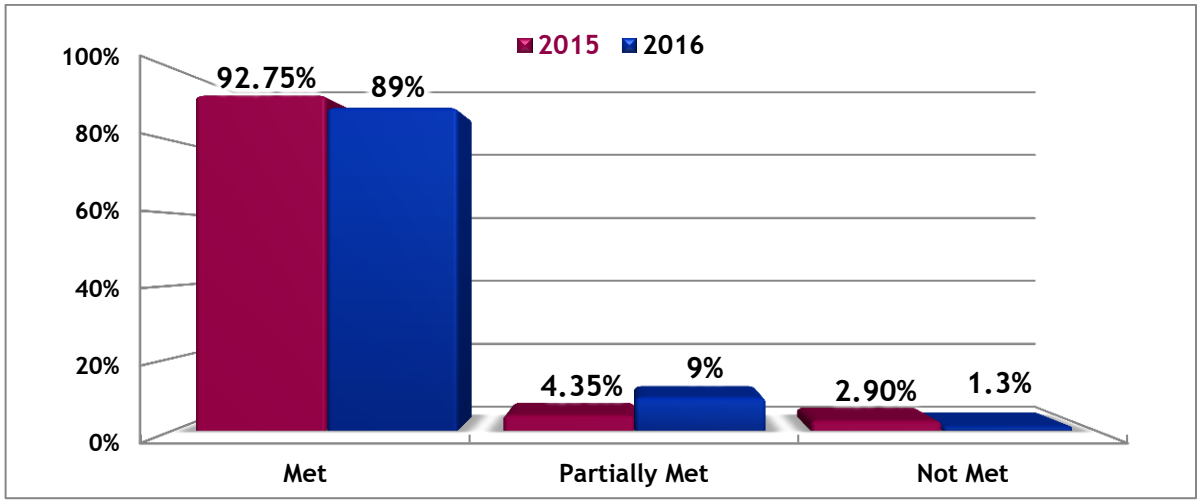


Table 3: Provider Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements	Met	Partially Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant	Met	Partially Met
	The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Partially Met	Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Not Met	Partially Met
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Partially Met
	The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Met	Partially Met
	The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Partially Met	Met
Continuity of Care	The MCO monitors continuity and coordination of care between the PCPs and other providers	Not Met	Met

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Practitioner Medical Records	The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- In 2016, Select Health conducted a chart audit to identify physical health/behavioral health coordination and collaboration between PCPs and behavioral health providers.
- Annual screening is performed for ownership disclosure of credentialed providers/facilities to identify if any ownership changes have taken place. The information is logged and new forms are requested if changes are identified.

Weaknesses

- The *Credentials Program 2016* and *Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing*, do not specify that the Medicare Opt Out report is verified, as applicable, for recredentialing.
- The following issues were identified with the Credentialing Committee:
    - The Credentialing Committee membership list shows Dr. David Soper as a voting member; however, committee meeting minutes show that he was not on the roster since December, 2015.
    - Dr. Melissa Pearce (medical director) is a voting member of the committee yet she does not show on the Credentialing Committee membership list.
    - Dr. Greg Barabell shows as the committee chair and that he is a voting member of the committee; however, committee meeting minutes indicate that he only votes in case of a tie. This is not documented in the Credentialing Committee list or the *2016 QAPI Program Description* which also indicates on page 17 that the committee chair has voting privileges.
- One recredentialing file reviewed showed the malpractice insurance was expiring on 7/15/16 and the Credentialing Committee approval was received on 6/24/16. Select Health stated that the malpractice insurance only has to be active when the Credentialing Committee reviews the information. However, *Policy CR.100.SC* states that if a document will expire within 30 days of receipt, they will outreach for an updated certificate. Select Health received the copy of the malpractice insurance information on 6/20/16 and the expiration date was 7/15/16, so according to *Policy CR.100.SC*, the updated information should have been requested.

- *Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality*, references *Policy 154.300, Review of Potential Quality of Care Cases*, which was not received in the desk materials. A copy of *Policy QM154.300* was received after the onsite and this is an AmeriHealth Caritas policy named, "Review of Potential Quality of Care Concerns" that is not specific to Select Health.
- The *Credentials Program 2016* and *Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process*, contains inconsistent information regarding the credentialing/recredentialing process for organizational providers.
- The provider-to-member ratios for psychiatrists and psychologists are incorrect in *Policy NM 159.304, Behavioral Health Provider/ Practitioner Geographic Access*.
- Policies *NM 159.206, Availability of Practitioners*, and *NM 150.304, Behavior Health Provider Availability*, state Select Health monitors the geographic availability annually and do not specify GeoAccess reports are conducted bi-annually.
- *Policy PNO 170.201, Provider Data Change/Update Policy for FACETS and Directories*, states that hours of operations and accreditation (if any) are listed in the paper and online *Provider Directories*. However, this information is not listed in the paper *Primary Care Directory* or the *Specialist & Ancillary Directory* received in the desk materials.
- Select Health measures appointment availability through analyzing questions on the annual CAHPS 5.0 survey and through monitoring ongoing grievances. The CAPHS survey for 2015 showed that getting needed care and getting care quickly (appointment access) had trended down from the previous year.
- *Policy NM 159.306* states 7 business days for the standard, "post-hospital discharge follow-up"; however, the measurement in the access survey and page 24 of the *Provider Manual* state a 7 day timeframe.
- Page 5 of the *Member Handbook* incorrectly states 4-6 weeks for PCP "routine visits" when the *SCDHHS Contract, Section 6.2.2.1.2*, states a timeframe of 4 weeks.
- The provider access study results did not increase from the previous year review. The successful answer rate was 39% for the current and 39% for the previous year.
- Select Health does not appear to have any pre/post natal or obstetric guidelines listed on the website.

Quality Improvement Plans

- Update the *Credentials Program 2016* and *Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing*, to include that the Medicare Opt Out report is verified, as applicable, for recredentialing.

- Update the Credentialing Committee list of members to reflect current members of the committee. Update the Credentialing Committee list of members and the *2016 QAPI Program Description* to reflect the Credentialing Committee chair only votes in case of a tie.
- Update the *Credentials Program 2016* and/or *Policy CR.103.SC* to reflect consistent information regarding organizational providers.
- Update *Policy NM 159.304, Behavioral Health Provider/Practitioner Geographic Access*, to reflect the correct provider-to-member ratios for psychiatrists and psychologists.
- Update policies *NM 159.206, Availability of Practitioners*, and *NM 150.304, Behavior Health Provider Availability*, to include that GeoAccess reports are conducted bi-annually.
- Address the inconsistency of information between the paper provider directories and *Policy PNO 170.201, Provider Data Change/Update Policy for FACETS and Directories*.
- Regarding member's access to their providers, identify and address barriers in the update process so that having up-to-date contact information for members is not an issue.

Recommendations

- Ensure that outreach for an updated document/certificate is performed for credentialing/ recredentialing when the expiration date is within 30 days of receipt.
- Update *Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality*, to reflect the correct reference for the Select Health policy called, "Review of Potential Quality of Care Concerns". The AmeriHealth policy *QM 154.300* is not specific to the SC line of business.
- Consider conducting a provider appointment access study to identify member access issues.
- Update the website to include pre/post natal or obstetric guidelines that have adopted by Select Health.

C. Member Services

The review of Member Services included policies and procedures, member rights, and member materials, along with the handling of grievances, disenrollment, and practitioner changes. Select Health's Member Services call center staff are available via toll-free telephone number and TTY services Monday through Friday from 8:00 a.m. to 9:00 p.m., and Saturday and Sunday from 8:00 a.m. to 6:00 p.m. Outside of normal hours of operation, members have the option to leave a message for Member Services or to speak with the Nurse Help Line, which is available 24 hours a day, seven days a week.

Within 14 days of receiving enrollment information, Select Health provides new members with a packet of information to inform about the health plan and its programs, services, and benefits. The packet includes a *Member Handbook, Co-Payment Reference Guide, Notice of Privacy Practices,* and *Quick Start Guide*. The *Member Handbook* is organized and contains most of the information required by the *SCDHHS Contract; however,* information required by the *SCDHHS Contract, Sections 3.9.1.25* and *3.9.1.26,* is missing. During onsite discussion, Select Health staff disclosed this has already been identified as an issue and the *Member Handbook* is currently being revised to include these requirements. Information required by the *SCDHHS Contract, Section 3.9.1.31,* was not found in the *Member Handbook* and has not been identified as an issue by health plan staff. Along with the recommendation to add the information required by the *SCDHHS Contract,* additional recommendations were offered to improve the information presented in the *Member Handbook*.

Onsite discussion confirmed Select Health provides appropriate notification to members regarding changes to services and benefits; however, no policy was found addressing the requirements and processes for providing this notification. Select Health staff stated that a policy is in place. CCME requested a copy of this policy but it was not received.

Select Health contracts with a certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor to conduct annual member satisfaction surveys. Survey response rates of 23% (Child) and 20% (Adult) were noted to be lower than the previous year's rates. Recommendations for increasing survey response rates were offered during the onsite visit. The Utilization Management Department, Quality of Clinical Care Committee, and the Quality Assessment Performance Improvement Committee are involved in generating interventions and initiatives to address problematic areas of member satisfaction.

Documentation of grievance requirements and processes was thorough and contained all pertinent information in policies and the *Member Handbook*. However, the *Provider Manual* does not define the timeliness requirement for grievance resolution and notification. Review of grievance files revealed several did not meet the resolution and notification timeliness requirements specified in the *SCDHHS Contract* and Select Health's grievance policy. One grievance file containing a possible clinical issue did not appear to be reviewed by an appropriate reviewer, as required by *Policy MEM 129.101, Member Grievances and Appeals Process*.

As noted in the chart below, 92% of the standards for Member Services received a score of "Met". Standards scored as "Partially Met" are related to lack of a policy addressing member notification requirements for changes in services and benefits, grievance information in the *Provider Manual*, and grievance file review findings.

Figure 4: Member Services Findings

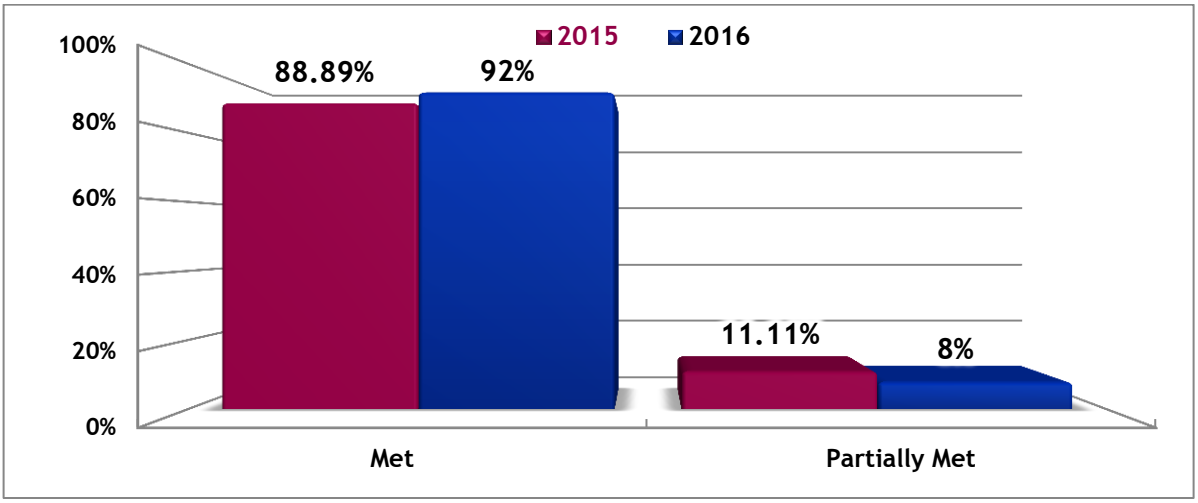


Table 4: Member Services Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Member MCO Program Education	Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled	Partially Met	Met
	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Partially Met
Member Satisfaction Survey	The MCO reports the results of the member satisfaction survey to providers	Partially Met	Met
Grievances	The procedure for filing and handling a grievance	Partially Met	Met
	The MCO applies the grievance policy and procedure as formulated.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- The *Member Handbook* includes a worksheet for members to organize medical concerns and questions prior to an appointment with their PCP or other provider.

- To maintain service standard compliance, staff in other Member Services roles are cross-trained to assist the call center staff in times of high call volume.
- Member Services staff provide telephonic orientation to members newly enrolled in the health plan.
- The *Grievance and Appeal Summary for 2015* contains thorough analyses of causes and factors for grievances, interventions completed in 2015, and opportunities for 2016.

Weaknesses

- The *Member Handbook* and *Provider Manual* include information on covered benefits and services; however, newborn hearing screenings are not addressed in the *Member Handbook*.
- The *Member Handbook*, page 23, includes a statement within the "Members' and Potential Members' Bill of Rights" section that emergency services do not require prior authorization. However, page 9 of the *Member Handbook* contains a section titled "Emergency and Urgent Care" which does not indicate that emergency services do not require prior authorization.
- The Select Health "Well Care Center" webpage is missing telephone numbers and links to obtain more information about EPSDT services.
- The *SCDHHS Contract, Section 11.2.9.1*, requires SCDHHS' fraud hotline, fraud email address, and toll-free line to be placed in a prominent position in all member communications so that members may easily identify the information in the materials. This information, located on pages 26-27 of the *Member Handbook*, is not displayed in a prominent location.
- The *SCDHHS Contract, Section 3.9.1.31*, requires the *Member Handbook* to inform members of additional information that is available upon request, including information on the structure and operation of Select Health, physician incentive plans, and service utilization policies. The information specified in these sections of the contract is not found in the *Member Handbook*.
- The *SCDHHS Policy & Procedure Guide, Appendix 1*, states members have the right to receive notice of any significant changes in the benefits package at least 30 days before the intended effective date of the change. However, no policy was submitted which addresses member notification of changes to services or benefits.
- Discrepancies were noted in the disease management programs in various documents: The *Member Handbook* lists the Breathe Easy Program, the Bright Start Program, and the In Control Program, but does not include the Heart First or Sickle Cell Programs which are listed in the *Provider Manual*. The Make Every Calorie Count Program is included in the *Case Management Program Description* but not listed in the *Member Handbook* or *Provider Manual*.

- Member Satisfaction Survey response rates of 23% (Child) and 20% (Adult) are lower than the previous year's (2014) rates of 29% for adult and 30% for children.
- The *Provider Manual* does not define the timeframe for grievance resolution but provides information on extensions of grievance resolution timeframes. Page 46 states Select Health is required to investigate grievances (not related to the physical condition of the office) and respond to the member within 5 business days.
- Issues noted during review of grievance files included:
    - Several grievance files reflected resolutions and notifications which were not compliant with the 90-day requirement found in the *SCDHHS Contract, Amendment Two, Section 9.1.6.1.1*, and *Policy MEM 129.101, Member Grievances and Appeals Process*.
    - One grievance file containing a possible clinical issue did not appear to be reviewed by an appropriate reviewer, as required by *Policy MEM 129.101, Member Grievances and Appeals Process*. In addition, this file reflected an inappropriate resolution that the member was financially liable for an emergency room visit at an out-of-network facility. The *SCDHHS Contract, Section 4.6.9*, states, "The CONTRACTOR must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the CONTRACTOR consistent with 42 CFR 438.114."

Quality Improvement Plans

- Include in a policy the requirements and processes for notifying members of changes to services and/or benefits.
- Include the grievance resolution timeframe in the *Provider Manual*.
- Ensure grievance resolutions and notifications are compliant with timeliness requirements specified in the *SCDHHS Contract, Amendment Two, Section 9.1.6.1.1*, and *Policy MEM 129.101, Member Grievances and Appeals Process*.
- Ensure that grievances involving possible clinical issues are reviewed by an appropriate reviewer and that resolutions are compliant with contract requirements.

Recommendations

- Include information on coverage of newborn hearing screenings in the *Member Handbook*.
- Update the "Emergency and Urgent Care" section (page 9) of the *Member Handbook* to include that emergency services require no prior authorization.
- Update the Select Health webpage titled "Well Care Center" to include the missing telephone numbers and links.

- Ensure information on reporting fraud, waste, and abuse, appear in a prominent location in the *Member Handbook*.
- Ensure information required by the *SCDHHS Contract, Section 3.9.1.31,* is added to the *Member Handbook*.
- Update the *Member Handbook* and *Provider Manual* to include all disease management programs available to members.
- Continue working with vendors to increase response rates for the Child and Adult member satisfaction surveys.

D. Quality Improvement

Select Health's *Quality Assessment and Performance Improvement 2016 Program Description* outlines the existing program for measuring and improving the care and services received by members and their providers. The program description discusses the objectives and goals included in the Quality Improvement workplan.

The Quality Assessment Performance Improvement Committee oversees Select's efforts to measure, manage, and improve the quality of care and services delivered to plan members. Select Health's Market President, Rebecca Engelman, chairs the Quality Assessment Performance Improvement Committee. Membership includes senior executives and directors, network providers, and staff from each area of the health plan. The Quality Assessment Performance Improvement Committee meets bi-monthly and has defined a quorum as at least 50% of voting members in attendance.

Performance Measure Validation

As part of the EQR for Select Health, CCME conducted a validation review of the HEDIS® performance measures following the protocols developed by CMS. This process assesses the production of these measures by the plan to confirm reported information is valid.

Select Health uses Inovalon, a certified software organization, for calculation of HEDIS rates. The comparison from the previous to the current year revealed a strong increase in Counseling for Physical Activity, Counseling for Nutrition, and BMI Percentile measures. The most problematic measure was Annual Monitoring for Patients on Persistent Medications (mpm). Specifically, monitoring those on Digoxin decreased from 93% in the previous measurement to 48% in the most recent measurement. For measures that were reportable, there are mostly positive results. All relevant HEDIS performance measures are detailed in *Table 5: HEDIS Performance Measure Data*.

Table 5: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	HEDIS 2013	HEDIS 2014	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	65.84%	82.13%	+16.29%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	25.06%	68.21%	+43.15%
Counseling for Nutrition	39.90%	56.07%	+16.17%
Counseling for Physical Activity	34.06%	52.10%	+18.04%
Childhood Immunization Status (cis)			
DTaP	81.75%	73.07%	-8.68%
IPV	89.29%	86.09%	-3.20%
MMR	91.00%	87.42%	-3.58%
HiB	87.83%	82.78%	-5.05%
Hepatitis B	83.21%	84.55%	+1.34%
VZV	92.94%	87.86%	-5.08%
Pneumococcal Conjugate	82.48%	75.06%	-7.42%
Hepatitis A	84.67%	82.34%	-2.33%
Rotavirus	68.61%	76.16%	+7.55%
Influenza	42.09%	43.93%	+1.84%
Combination #2	74.45%	66.89%	-7.56%
Combination #3	70.56%	64.46%	-6.10%
Combination #4	64.72%	62.25%	-2.47%
Combination #5	55.72%	58.94%	+3.22%
Combination #6	34.55%	37.53%	+2.98%
Combination #7	51.09%	57.40%	+6.31%
Combination #8	33.33%	35.98%	+2.65%
Combination #9	27.25%	34.88%	+7.63%
Combination #10	26.28%	33.33%	+7.05%
Immunizations for Adolescents (ima)			
Meningococcal	62.04%	70.50%	+8.46%
Tdap/Td	68.13%	86.95%	+18.82%
Combination #1	60.83%	68.93%	+8.10%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	13.18%	23.23%	+10.05%
Lead Screening in Children (lsc)	61.31%	66.67%	+5.36%
Breast Cancer Screening (bcs)	63.81%	60.77%	-3.04%

MEASURE/DATA ELEMENT	HEDIS 2013	HEDIS 2014	PERCENTAGE POINT DIFFERENCE
Cervical Cancer Screening (ccs)	65.31%	63.33%	-1.98%
Chlamydia Screening in Women (chl)			
16-20 Years	51.72%	48.94%	-2.78%
21-24 Years	62.12%	58.20%	-3.92%
Total	54.48%	51.39%	-3.09%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	73.87%	78.24%	+4.37%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	32.16%	33.44%	+1.28%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	57.14%	66.25%	+9.11%
Bronchodilator	81.51%	80.54%	-0.97%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	59.25%	62.03%	+2.78%
5-11 Years - Medication Compliance 75%	32.91%	34.88%	+1.97%
12-18 Years - Medication Compliance 50%	52.81%	54.68%	+1.87%
12-18 Years - Medication Compliance 75%	26.47%	30.16%	+3.69%
19-50 Years - Medication Compliance 50%	54.04%	59.13%	+5.09%
19-50 Years - Medication Compliance 75%	35.74%	36.30%	+0.56%
51-64 Years - Medication Compliance 50%	74.58%	68.81%	-5.77%
51-64 Years - Medication Compliance 75%	57.63%	49.54%	-8.09%
Total - Medication Compliance 50%	56.81%	59.41%	+2.60%
Total - Medication Compliance 75%	31.06%	33.66%	+2.60%
Asthma Medication Ratio (amr)			
5-11 Years	79.45%	68.66%	-10.79%
12-18 Years	67.58%	56.92%	-10.66%
19-50 Years	55.26%	50.27%	-4.99%
51-64 Years	44.09%	52.03%	+7.94%
Total	72.67%	62.51%	-10.16%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	42.05%	48.89%	+6.84%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	79.66%	73.17%	-6.49%

MEASURE/DATA ELEMENT	HEDIS 2013	HEDIS 2014	PERCENTAGE POINT DIFFERENCE
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	NR	75.56%	NA
Statin Adherence 80% - 21-75 years (Male)	NR	80.51%	NA
Received Statin Therapy - 40-75 years (Female)	NR	76.16%	NA
Statin Adherence 80% - 40-75 years (Female)	NR	80.49%	NA
Received Statin Therapy - Total	NR	75.84%	NA
Statin Adherence 80% - Total	NR	80.50%	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	82.85%	89.93%	+7.08%
HbA1c Poor Control (>9.0%)	56.39%	49.83%	-6.56%
HbA1c Control (<8.0%)	35.77%	41.49%	+5.72%
HbA1c Control (<7.0%)	25.79%	30.19%	+4.40%
Eye Exam (Retinal) Performed	50.73%	56.25%	+5.52%
Medical Attention for Nephropathy	79.56%	92.19%	+12.63%
Blood Pressure Control (<140/90 mm Hg)	46.17%	53.99%	+7.82%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	NR	59.93%	NA
Statin Adherence 80%	NR	55.09%	NA
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	68.67%	70.10%	+1.43%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	45.65%	48.43%	+2.78%
Effective Continuation Phase Treatment	30.53%	32.10%	+1.57%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	41.59%	40.54%	-1.05%
Continuation and Maintenance (C&M) Phase	54.39%	51.48%	-2.91%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	66.32%	65.55%	-0.77%
7-Day Follow-Up	46.23%	42.30%	-3.93%

MEASURE/DATA ELEMENT	HEDIS 2013	HEDIS 2014	PERCENTAGE POINT DIFFERENCE
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	84.21%	76.99%	-7.22%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	73.45%	73.66%	+0.21%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA	80.95%	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	73.15%	70.33%	-2.82%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NR	23.08%	NA
6-11 Years	NR	19.24%	NA
12-17 Years	NR	26.55%	NA
Total	NR	23.87%	NA
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mph)			
ACE Inhibitors or ARBs	89.89%	88.18%	-1.71%
Digoxin	93.02%	48.28%	-44.74%
Diuretics	89.20%	87.75%	-1.45%
Total	87.57%	87.62%	+0.05%
Non-Recommended Cervical Cancer Screening in Adolescent Females (n's)	6.15%	2.35%	-3.80%
Appropriate Treatment for Children With URI (uri)	79.72%	85.41%	+5.69%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	18.39%	22.77%	+4.38%
Use of Imaging Studies for Low Back Pain (lbp)	74.77%	72.81%	-1.96%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	0.00%	NA
6-11 Years	NR	1.30%	NA
12-17 Years	NR	1.36%	NA
Total	NR	1.32%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	86.25%	82.58%	-3.67%
45-64 Years	91.05%	90.41%	-0.64%
65+ Years	NR	100.00%	NA
Total	87.70%	84.61%	-3.09%

MEASURE/DATA ELEMENT	HEDIS 2013	HEDIS 2014	PERCENTAGE POINT DIFFERENCE
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	98.65%	97.59%	-1.06%
25 Months - 6 Years	91.23%	88.84%	-2.39%
7-11 Years	92.96%	91.71%	-1.25%
12-19 Years	91.24%	89.71%	-1.53%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	91.04%	91.50%	+0.46%
Postpartum Care	74.63%	75.35%	+0.72%
Call Answer Timeliness (cat)	82.31%	85.27%	+2.96%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	NR	73.33%	NA
6-11 Years	NR	60.78%	NA
12-17 Years	NR	57.51%	NA
Total	NR	59.35%	NA
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	7.82%	5.67%	-2.15%
21-40 Percent	3.35%	3.12%	-0.23%
41-60 Percent	6.47%	4.25%	-2.22%
61-80 Percent	14.93%	8.22%	-6.71%
81+ Percent	67.44%	78.75%	+11.31%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	0.00%	0.72%	+0.72%
1 Visit	2.26%	2.17%	-0.09%
2 Visits	1.26%	1.21%	-0.05%
3 Visits	4.77%	4.11%	-0.66%
4 Visits	9.55%	6.76%	-2.79%
5 Visits	18.34%	16.43%	-1.91%
6+ Visits	63.82%	68.60%	+4.78%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	64.05%	69.48%	+5.43%
Adolescent Well-Care Visits (awc)	48.66%	53.20%	+4.54%

KEY: NR: Not reported; NA: Data not available

Performance Improvement Project Validation

The validation of the performance improvement projects (PIPs) was done in accordance with the protocol developed by CMS titled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0 (September 2012)*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedureImprovement strategies

Four projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. They include Comprehensive Diabetes Care, Chlamydia Screening, Post discharge follow up for Patients with Exacerbation of Asthma, and follow-up After ER discharge. Table 6, *Performance Improvement Project Validation Scores,* details the result.

TABLE 6: Performance Improvement Project Validation Scores

PROJECT	VALIDATION SCORE
Comprehensive Diabetes Care	95/110 = 86% CONFIDENCE IN REPORTED RESULTS
Chlamydia Screening	42/78 = 54% RESULTS NOT CREDIBLE
Post Discharge Follow-Up for members with Asthma Exacerbation	52/82 = 65% LOW CONFIDENCE IN REPORTED RESULTS
Coordination of Care: ER Follow-up	59/85 = 69% LOW CONFIDENCE IN REPORTED RESULTS

One study, Comprehensive Diabetes Care, was submitted for validation during the previous EQR and validated again this year. Changes consistent with recommendations made last year concerning this project were not reflected in the project documents submitted with the desk materials. Issues still exist with the rates reported and the labels for the remeasurement periods.

The other projects that were validated include Chlamydia Screening, Post Discharge Follow-Up for Members with Asthma Exacerbation, and Coordination of Care: ER Follow-up. The forms documenting these projects did not indicate a research question for two of the projects (Coordination of Care: ER Follow-up and Post D/C Follow-up for members with asthma exacerbation). The Chlamydia Screening project has three separate questions that might be combined into one driving question.

Coordination of Care received a *Low Confidence* validation score of 69%. Comprehensive Diabetes Care received an 86% *Confidence in Reported Results score*. The Chlamydia Screening PIP was validated as *Not Credible*. Post Discharge Follow-Up for Members with Asthma Exacerbation received a *Low Confidence in Reported Results* score of 65%. The four projects failed to meet the validation protocol requirements. The following tables list the specific errors, by project, along with recommendations.

Table 7: Comprehensive Diabetes Care

Section	Reasoning	Recommendation
Were qualified staff and personnel used to collect the data?	Staff working with data are not documented.	Include staff and qualifications of staff who are pulling and collecting data.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The labels for the remeasurement periods are not similar across measures. For measure 1, the 2012 year is labeled Remeasurement 12, but for measure 2, the 2012 year is labeled Remeasurement 4. Remeasurements should be consistently labeled across measures. In addition, the rates do not match the numerator and denominator. For example, for HbA1c, the 2013 measurement year has 443 as the numerator and 548 as the denominator, which is 80.8%, but the rate is shown as 82.85%. This also occurs in the HbA1c Poor control measure, Monitoring Diabetic Neuropathy measure, and the Eye exam measure.	Consistently label remeasurement periods across all measures. Rates should be corrected to show accuracy based on numerator and denominator.
Was there any documented, quantitative improvement in processes or outcomes of care?	All but one measure is showing improvement in outcomes. The HbA1c Poor control rate is increasing, whereas it should be decreasing to show improvement.	Continue to focus interventions that would impact the measures that are not improving toward goal rates.
Is there any statistical evidence that any observed	Statistical tests were not conducted to compare sample	When using sampling methodology, include

Section	Reasoning	Recommendation
performance improvement is true improvement?	rates over time.	statistical testing with p-values to determine if rates are significantly different from previous measurement time period.

Table 8: Chlamydia Screening

Section	Reasoning	Recommendation
Was/were the study question(s) stated clearly in writing?	Study questions were found in the documentation, however, there were three questions listed that did not directly match up with the interventions. There were several interventions, and only three were mentioned in the research questions.	Write one research question that encompasses the entirety of the project in a clear manner, such as "Will provider and member interventions improve chlamydia screening rates for women 16-24 years of age to the goal rate of 62%?"
Did the study use objective, clearly defined, measurable indicators?	Measure was not clearly defined.	Include a definition of the numerator and denominator in the documentation.
Did the study design clearly specify the sources of data?	Study design does not describe the sources of the data.	Include data sources (administrative data, claims, medical review, etc).
Were qualified staff and personnel used to collect the data?	Staff working with data are not documented.	Include staff and qualifications of staff who are pulling and collecting data.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Several interventions were listed, but documentation did not address which barriers are being addressed by each intervention.	Documentation should include a Table that displays the interventions and which barriers are addressed by those interventions.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The goal rate is 62% overall, but the overall rate was not provided, only sub-group rates were offered. The rates for sub-groups of age, race, etc. did not show the numerator and denominator for any of the rates given.	Document results in table that displays numerator and denominator for each rate that is reported. Document the overall rate of the HEDIS CHL measure to compare to the target rate of 62%.

Table 9: Post Discharge Follow-Up for members with Asthma Exacerbation

Section	Reasoning	Recommendation
Was/were the study question(s) stated clearly in writing?	Study questions were not found in the documentation.	Include a study question in the documentation.
Did the study design clearly	Study design does not describe the	Include data sources (administrative data, claims,

Section	Reasoning	Recommendation
specify the sources of data	sources of the data.	medical review, etc).
Did the study design prospectively specify a data analysis plan?	Data analysis plan was not provided.	Include a specific statement on the data analysis plan, including how often data will be analyzed.
Were qualified staff and personnel used to collect the data?	Staff working with data are not documented.	Include staff and qualifications of staff who are pulling and collecting data.
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Several interventions were listed, but documentation did not address which barriers are being addressed by each intervention.	Include a Table that displays the interventions and the barrier to which that intervention is applicable. The documentation should reflect which interventions addressed each barrier/opportunity.
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	The rates for both measures were reported, and whether or not they met the Goal. The numerator and denominator for the rates were not documented.	Document the numerator and denominator at each measurement in addition to the rate.
Was there any documented, quantitative improvement in processes or outcomes of care?	There was an initial increase in rates, but the past two years have noted a decrease in the rates.	Focus on specific barriers and interventions to address those barriers in efforts to increase the rates to meet goal increase each year.

Table 10: Coordination of Care: ER Follow-up

Section	Reasoning	Recommendation
Was/were the study question(s) stated clearly in writing?	Study questions were not found in the project documentation.	Include study question in documentation.
Did the study design prospectively specify a data analysis plan?	Data collection cycle nor data analysis plan were provided.	Include statement regarding data collection cycle and plan to analyze data annually.
Were qualified staff and personnel used to collect the data?	Staff working with data are not documented.	Include staff and qualifications of staff who are pulling and collecting data.
Were reasonable interventions undertaken to address causes/barriers identified through data	Several interventions were listed, however, the barriers that each intervention addresses is not clear.	Restructure documentation to indicate which barriers are being addressed by the Planned Opportunities section.

Section	Reasoning	Recommendation
analysis and QI processes undertaken?		
Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Rates are correct based on numerator and denominators in findings table. The pie chart that is shown at the end of the documentation does not offer the most recent information. The bar chart labels are not accurate, and can create confusion in interpreting the results. The blue bar is labeled "Population" but the population includes the numerator and denominator, not only the denominator as the bar chart suggests. Instead, the blue bar should be labeled as "# without PCP visit within 30 days"	When offering graphic displays, include the most recent values in the bar charts and pie charts. Fix labels on bar chart for accuracy.

Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 5, Quality Improvement Findings, indicate that 93% of the standards received a "Met" score, 7% received a "Not Met" score. The performance improvement projects did not meet validation standards and received a "Not Met" score.

Figure 5: Quality Improvement Findings

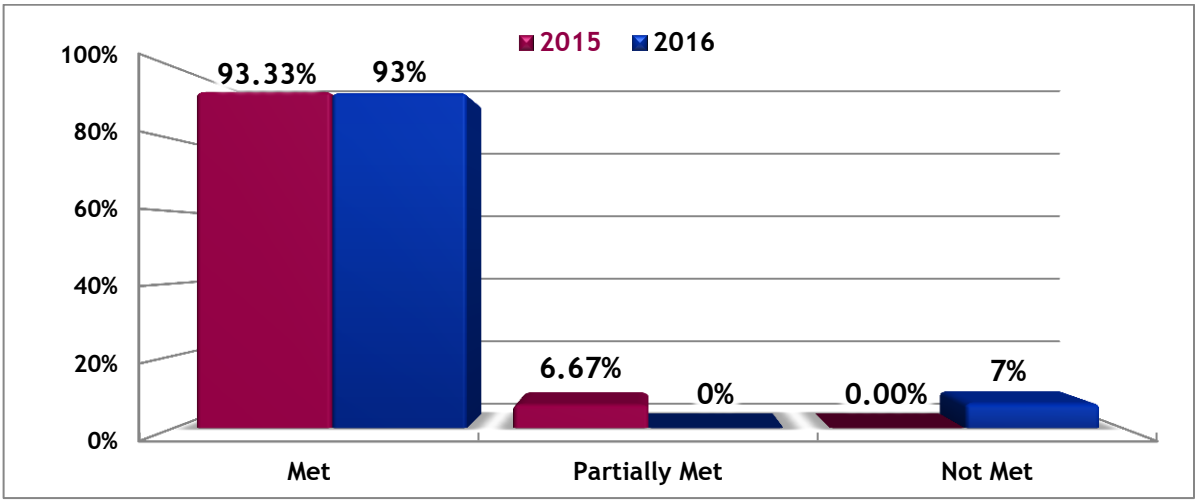


TABLE 11: Quality Management Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- Very strong provider participation on the Quality Assessment Performance Improvement Committee.

Weaknesses

- The performance improvement project validation scores were low overall. The documentation suggests that recommendations made last year were not integrated into the documentation. The projects are not including several of the essential elements of the CMS Protocol.

Quality Improvement Plan

- Correct the errors identified in the performance improvement projects.

E. Utilization Management

The Utilization Management review includes a review of policies and procedures, the *Utilization Management Program Description*, and review of approval, denial, appeal, and case management files.

Select Health has a comprehensive *Integrated Utilization Management (UM) Program Description* and an *Integrated Care Management Program Description* that, along with numerous policies and procedures, guide staff in the implementation of utilization and case management functions. The Select Health Regional Senior Medical Director, Dr. Burnham, serves as the medical management coordinator for Select Health and is responsible for development, implementation, and oversight of all aspects of the Select Health integrated UM program. Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-rater Reliability testing. Recent results confirm scores above the 90 percent benchmark were obtained by all staff. The review of approval and denial files confirms Select Health performs reviews using appropriate criteria with notification promptly communicated to provider and member, as applicable.

Select Health policies define the delivery of pharmacy services and include the contract requirements for a pharmacy lock-in program. The *Member Handbook* does not inform members about the provision of a five-day medication supply while waiting for prior authorization or when specific medicines can be filled for a 90-day period. Select Health developed a Preferred Provider Program that is briefly mentioned in one policy. A detailed description of this program or how providers learn about it was not provided.

Inconsistencies in the appeals process were noted in *Policy MED 131.300, Member Appeals Process*, and in one letter template. Appeals files are well-documented with appeals conducted by appropriate physician reviewers. Acknowledgement timeframes were met in all except two files. Decisions were made in a timely fashion. However, 2 resolution letters dated beyond the timeframe for resolution.

As noted in the chart below, 89% of the standards in the Utilization Management section were scored as "Met". Scores of "Partially Met" were related to policy inconsistencies in the appeals processes and an error in 1 (one) letter template. All standards scored as "Partially Met" are discussed in detail in the Weaknesses section of the report.

Figure 6: Utilization Management Findings

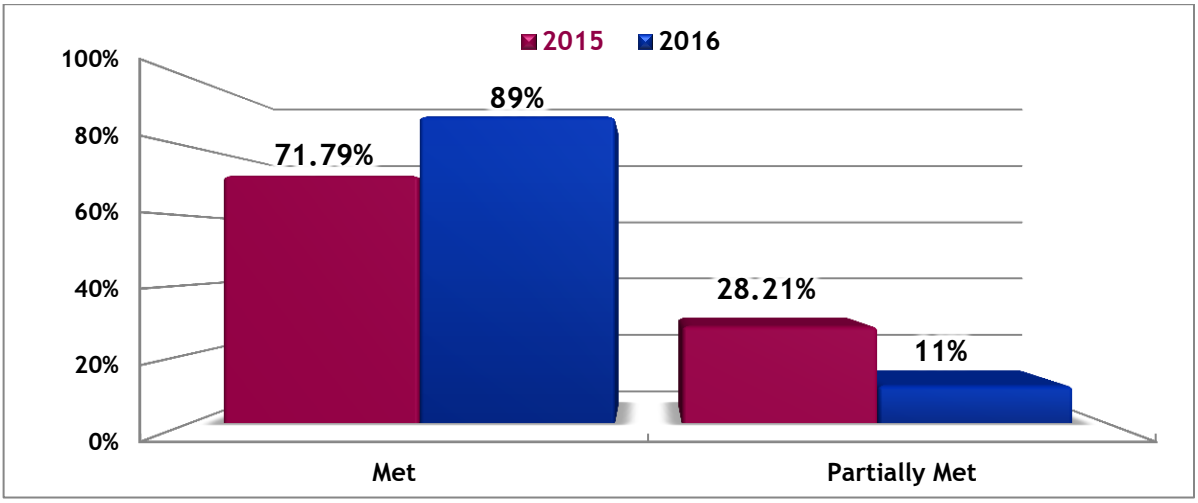


TABLE 12: Utilization Management Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Medical Necessity Determinations	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Partially Met	Met

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all members across all reviewers	Partially Met	Met
	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Partially Met
	If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Partially Met	Met
Appeals	The definitions of an action and an appeal and who may file an appeal	Partially Met	Met
	Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Partially Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met
	Written notice of the appeal resolution as required by the contract	Met	Partially Met
	Other requirements as specified in the contract	Partially Met	Met
	The MCO applies the appeal policies and procedures as formulated	Partially Met	Met
Evaluation of Over/ Underutilization	The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

Strengths

- Utilization review timeframes detailed in the *Integrated UM Program Description* reflect 96.4-99.8 % compliance.
- Case Management files reflected thorough assessments are completed, goals are personalized, and managers continue to follow members and coordinate care among providers.

Weaknesses

- *Policy MEM 129.101, Member Grievances and Appeals,* states on page 5 that expedited authorization decision timeframes may be extended up to 2 calendar days. All other documents state the extension may be up to 14 calendar days.
- *Policy UM.003S, Standard and Urgent Prior Authorization*, mentions that providers may be recognized as a Preferred Provider and may be eligible for a simplified service authorization process that recognizes the provider's ability to manage care. A detailed description of this program was not found in the *UM Integrated Program Description* or other document.
- The *Member Handbook* does not include that members may obtain a 5-day emergency supply of medication when waiting for prior authorization or that a 90-day supply of medication can be filled for specific conditions.
- *SCDHHS Contract, Amendment 2, Section 9.1.1.3*.2, states appeals may be filed orally or in writing and unless the request is for an expedited resolution, must follow an oral filing with a written, signed appeal. The *Provider Manual* states on page 33 that appeals must contain a written request, but later on the same page it correctly states that appeals filed orally must be followed by a written, signed request.
- *Policy MEM 129.101, Member Grievances and Appeals*, pages 10-11, state if the member does not follow up in writing within 30 calendar days of the oral appeal, the appeal will be closed. If the written request is received within 90 days from the denial notification a new appeal will be initiated. This conflicts with *Policy MED 131.300*, page 3, which states if the member does not follow with the written request within 30 calendar days from the oral filing the appeal may be dismissed. However, the next sentence states if the written request is received within the 90 days to file an appeal, the timeframe for resolution begins with the written confirmation.
- The *Member Handbook* does not inform members that the written appeal request must be received within 30 days of the oral filing. It also does not include that the member has the right to review the case file regarding the appeal at any time during the process as found in *SCDHHS Contract, Section 9.1*.4.4.3.
- The "Appeal Expedited Status Denied" letter template states Select Health will send the outcome of the review in writing within 5 days of the decision. However, *Policy*

MEM 129.101 Member Grievances and Appeals Process, states standard resolution of appeals and notice to the affected parties is 30 days from the day the appeal was received.

Quality Improvement Plans

- Update *Policy MEM 129.101, Member Grievances and Appeals*, to be consistent with other documentation regarding the extension of expedited service authorizations.
- Update the *Member Handbook* to include information regarding a 5-day emergency supply of medication and a possible 90-day fill under certain circumstances. Reference the *SCDHHS Contract, Section 4.7.*3.
- Remove the statement in the *Provider Manual* that appeals must contain a written request.
- Update the language in *Policy MED 131.300* to align with *Policy MEM 129.101* which states the appeal will be closed if written confirmation is not received within 30 calendar days from the oral request and if the written request is submitted timely (within 90 days of the notice), a new appeal will be initiated.
- Update the *Member Handbook* to include the timeframe within which members must follow an oral appeal with the written request.
- Update the "Appeal Expedited Status Denied" letter template with the correct timeframe for notice to the affected parties.

Recommendations

- Include a description of Select Health's preferred provider program in a policy, and/or program description. Reference the *SCDHHS Contract, Section 8.4.2.7.*

F. Delegation

Select Health has delegation agreements with the following entities:

Table 13: Delegated Entities and Services

Delegated Entities	Delegated Services
Georgia Regents Greenville Hospital System Health Network Solutions Mary Black HealthNetwork Medical University of South Carolina Memorial Health Partners Regional Health Plus Roper St. Francis St. Francis Physician Services	Provider credentialing, recredentialing, ongoing monitoring, and decision making

Delegated Entities	Delegated Services
NIA	UM services and provider call center functions

Written agreements are in place with all entities performing delegated functions for Select Health. The agreements outline the entities' responsibilities, reporting requirements, oversight activities, and actions that may be taken for substandard performance. For credentialing delegation, the agreements include state-specific credentialing requirements. In addition, policies and procedures appropriately address delegation requirements and oversight.

Evidence of annual oversight activity was provided and reviewed for each delegated entity. In addition to the formal annual assessment, oversight is conducted through routine reporting from each delegate. Delegate performance is reported to and monitored by various Select Health committees, including the Quality Assessment Performance Improvement Committee, the Quality of Clinical Care Committee, the Quality of Service Committee, and the Credentialing Committee.

As noted in the chart below, both of the standards in Delegation received a "Met" score.

TABLE 14: Delegation Comparative Data

SECTION	STANDARD	2015 REVIEW	2016 REVIEW
Delegation	The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Not Met	Met
Delegation	The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2015 to 2016.

G. State Mandated Services

Select Health provides core benefits required by the *SCDHHS Contract*. The *Member Handbook* provides information on Early and Periodic Screening, Diagnostic, and

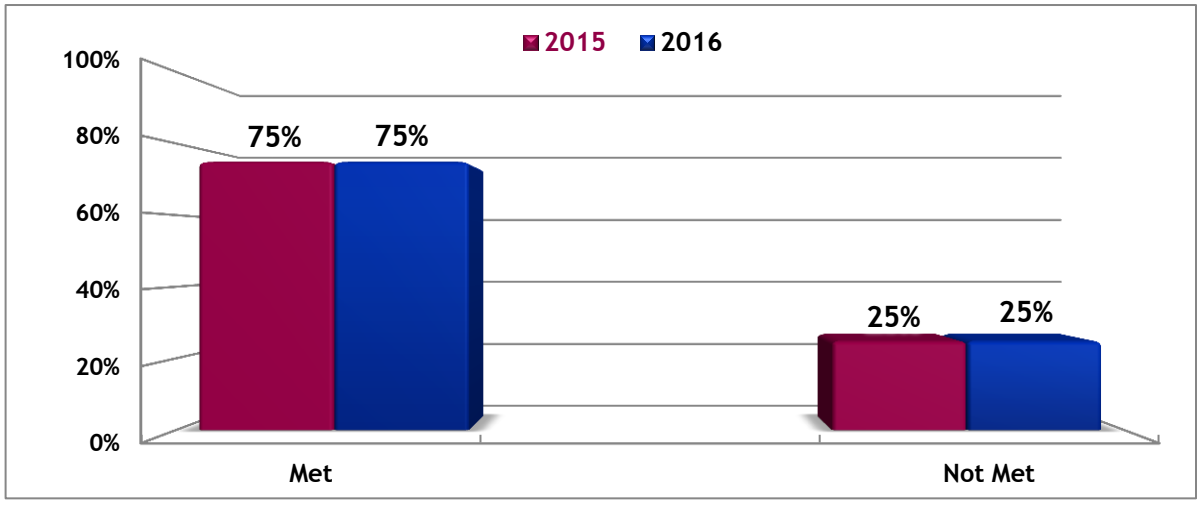
Treatment (EPSDT) services and the recommended schedule for EPSDT visits. The *Provider Manual* contains comprehensive information on EPSDT requirements. To encourage member participation in EPSDT and preventive health screenings, Select Health has established processes for outreach and notification activities. These include, but are not limited to, "Now Due" post cards, automated phone message reminders, birthday post cards, and letters encouraging members to obtain recommended or past due health services. Select Health provides care gap reports to providers on a quarterly basis. Providers are able to check for individual member care gaps via the provider portal and print member-specific worksheets for inclusion in the member's medical record.

Provider compliance with administering required immunizations is assessed via annual medical record reviews performed by trained nurse reviewers. Medical records are assessed for documentation of the immunization record for children and adolescents (18 years and younger) and documentation of preventative screening and services in accordance with Select Health practice guidelines.

All deficiencies identified in the previous external quality review were corrected with the exception of errors in Select Health's Quality Improvement Projects. The projects demonstrate that previously identified issues remain uncorrected.

As noted in the chart below, Select Health received a score of "Met" for 75% of the standards in the State-Mandated Services section. The score of "Not Met" is related to the uncorrected deficiencies from the previous external quality review.

Figure 7: State Mandated Services



Weaknesses

- Errors identified during the previous external quality review in Select Health's Performance Improvement Projects were not corrected.

Quality Improvement Plan

- Ensure that all deficiencies from the EQR are corrected and that the corrections are implemented.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

September 6, 2016

Ms. Rebecca Engelman
Market President
Select Health of South Carolina, Inc.
4390 Belle Oaks Drive, Suite 400
North Charleston, South Carolina 29405

Dear Ms. Engelman:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2016 External Quality Review (EQR) of Select Health is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **October 18th and 19th**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **September 20, 2016**.

Submission of all the desk materials will be different than in the past. This year we have a new secure file transfer website for uploading desk materials electronically to CCME. The file transfer site can be found at:

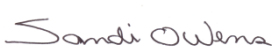
https://eqro.thecarolinascenter.org

Upon registering with a username and password, you will receive an email with a link to confirm the creation of your account. After you have confirmed the account, CCME will be notified and will send an automated email once the security access has been set up. Please bear in mind that while you will be able to log in to the website after the confirmation of your account, you will see a message indicating that your registration is pending, until CCME grants you the appropriate security clearance. I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. Ensuring successful upload of desk materials is our priority and we value the opportunity to provide support.

An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,



Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2016

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization. Please note this information will be used to conduct our telephone access study.

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2015, and 2016.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc…).

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members. Please include committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from March 2016 through August 2016. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings.

23. A copy of the Grievance, Complaint and Appeal logs for the months of August 2015 through August 2016.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development,

when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);

d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
e. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
f. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two network hospitals; and
        v. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files made in the months of August 2015 through August 2016. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and two acute inpatient rehabilitation files.
    d. Twenty-five utilization approval files (acute care and behavioral health) made in the months of August 2016 through August 2016, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

    Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://eqro.thecarolinascenter.org**
- **and submitted in the categories listed.**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2016

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Provide copies of the most recent GEO access reports run for provider network assessment.
3. Policy COM 220.101: Select Health of South Carolina (SHSC) “Editorial Review Process.”
4. 2012 Checklist Member Materials and 2012 General Guidelines Member Materials.
5. Provide copies of any policies related to RBHS specific services.
6. Delegation agreement for non-credentialing (UM, etc.) functions.
7. Provide copies of any reports showing assessment of provider appointment accessibility standards, i.e. routine within 4 weeks, urgent within 48 hours, etc.

Materials should be uploaded to the secure CCME EQR File Transfer site at https://egro.thecarolinascenter.org

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name	**Select Health**
Name of PIP	**CHLAMYDIA SCREENING**
Validation Period	2015
Review Performed	10/2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic selected based on research and analysis of enrollee care needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.

Component / Standard (Total Points)	Score	Comments
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**PARTIALLY MET**	Study questions are found in the documentation. However, there are three questions listed that do not directly match the interventions. There are several interventions and only three are mentioned in the research questions. Recommendation: Write one research question encompassing the entirety of the project in a clear manner. For example. "Will provider and member interventions improve chlamydia screening rates for women 16-24 years of age to the goal rate of 62%?"
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**NOT MET**	Measures are not clearly defined. Recommendation: Include a definition of the numerator and denominator in the documentation.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measures are related to health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire relevant population included.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly documents HEDIS CHL rate will be collected between 2014 and 2015.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Study design does not describe the sources of the data. Recommendation: Include data sources (administrative data, claims, medical review, etc.).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was conducted according to HEDIS.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Between 2014 and 2015, the data analysis plan provided analysis by race, ethnicity, language, and age.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NOT MET**	Staff with data access is not documented. Recommendation: Document staff, along with required qualifications, for all data access.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**PARTIALLY MET**	Several interventions were listed, but documentation did not address barriers being addressed by each intervention. Recommendation: Documentation includes a Table displaying the interventions and which barriers addressed each intervention.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	The overall goal rate is 62%, but only sub-group rates were offered. The rates for sub-groups of age, race, etc. did not show the numerator and denominator for any of the rates given. Recommendation**:** Document results in a table displaying the numerator and denominator for each rate reported. Document the overall rate of the HEDIS CHL measure to compare to the target rate of 62%.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Only one measurement conducted.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation includes both qualitative and quantitative discussion of results.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	No repeat measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	No repeat measurements.

Component / Standard (Total Points)	Score	Comments
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No repeat measurements.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No samples utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement cannot be measured.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

	Possible Score	Score		Possible Score	Score
Step 1			**Step 6**		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	0
Step 2			**Step 7**		
2.1	10	5	7.1	10	5
Step 3			**Step 8**		
3.1	10	0	8.1	5	5
3.2	1	1	8.2	10	0
Step 4			8.3	NA	NA
4.1	5	5	8.4	1	1
4.2	1	1	**Step 9**		
Step 5			9.1	NA	NA
5.1	NA	NA	9.2	NA	NA
5.2	NA	NA	9.3	NA	NA
5.3	NA	NA	9.4	NA	NA
Step 6			**Step 10**		
6.1	5	5	10.1	NA	NA
6.2	1	0			
6.3	1	1			

Project Score	42
Project Possible Score	78
Validation Findings	54%

AUDIT DESIGNATION
NOT CREDIBLE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name	**Select Health**
Name of PIP	**COORDINATION OF CARE – ER FOLLOW-UP**
Validation Period	2015
Review Performed	10/2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic selected based on research and analysis of enrollee care needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**NOT MET**	Study questions not found in the project documentation. Recommendation: Include study question in documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in processes of care.
STEP 4: Review The Identified Study Population		

Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire relevant population included.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design clearly describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection uses claim data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Neither the data collection cycle nor the data analysis plan was provided. Recommendation: Include statement regarding data collection cycle and plan to analyze data annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NOT MET**	Staff with data access is not documented. Recommendation: Document staff, along with required qualifications, for all data access.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**PARTIALLY MET**	Several interventions were listed. However, the barriers each intervention addresses is not clear. Recommendation: Restructure documentation to indicate which barriers are being addressed by the Planned Opportunities section.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	No analysis plan provided.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Rates are correct based on numerator and denominators in findings table. The pie chart shown at the end of the documentation does not offer the most recent information. The bar chart labels are not accurate and can create confusion in interpreting results. The blue bar is labeled "Population" but the population includes the numerator and denominator. Only the denominator is shown in the bar chart. Instead, the blue bar should be labeled as "Number Without PCP visit within 30 days." Recommendation: When offering graphic displays, include only the most recent values in bar and pie charts. Correct labels on bar chart for accuracy.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements are identified.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation includes both qualitative and quantitative discussion of results.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	There is documentation of improvement in the measure.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement is the result of several interventions.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical evidence is not applicable as sampling was not utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement only recently demonstrated More time is needed. The measure remained unchanged until the most recent measure.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

	Possible Score	Score			Possible Score	Score
Step 1				**Step 6**		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	0
1.3	1	1		6.6	5	0
Step 2				**Step 7**		
2.1	10	0		7.1	10	5
Step 3				**Step 8**		
3.1	10	10		8.1	NA	NA
3.2	1	1		8.2	10	5
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		**Step 9**		
Step 5				9.1	5	5
5.1	NA	NA		9.2	1	1
5.2	NA	NA		9.3	5	5
5.3	NA	NA		9.4	NA	NA
Step 6				**Step 10**		
6.1	5	5		10.1	NA	NA
6.2	1	1				
6.3	1	1				

Project Score	**59**
Project Possible Score	**85**
Validation Findings	**69%**

AUDIT DESIGNATION
LOW CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name	**Select Health**
Name of PIP	**COMPREHENSIVE DIABETES CARE**
Validation Period	2015
Review Performed	10/2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic selected based on research and analysis of enrollee care needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study questions found in the analysis section of project documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire relevant population included.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS Hybrid methodology utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid methodology utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS Hybrid methodology utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies collectable data, but the data collection cycle is not documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection conducted according to hybrid methods
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan provided.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NOT MET**	Staff with data access is not documented. Recommendation: Document staff, along with required qualifications, for all data access.

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers addressed by interventions are noted.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**NOT MET**	The labels for remeasurement periods are not similar across measures. For measure 1, the 2012 year is labeled Remeasurement 12, but for measure 2, the 2012 year is labeled Remeasurement 4. Remeasurements should be consistently labeled across measures. In addition, the rates do not match the numerator and denominator. For example, for HbA1c, the 2013 measurement year has 443 as the numerator and 548 as the denominator, which is 80.8%, but the rate is shown as 82.85%. This also occurs in the HbA1c Poor control measure, Monitoring Diabetic Neuropathy measure, and the Eye exam measure. Recommendation: Consistently label remeasurement periods across all measures. Rates should be corrected to show accuracy based on numerator and denominator.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements are identified.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation includes both qualitative and quantitative discussion of results.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALY MET**	All but one measure show improvement in outcomes. The HbA1c Poor control rate is increasing, whereas it should be decreasing to show improvement. Recommendation: Continue to focus interventions that would impact the measures that are not improving toward goal rates.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvements in rates relate to interventions and action steps.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Statistical tests not conducted to compare sample rates over time. Recommendation: When using sampling methodology, include statistical testing with p-values to determine if rates are significantly different from previous measurement time period.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Improvement only recently demonstrated. More time required to judge improvement.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

	Possible Score	Score		Possible Score	Score
Step 1			**Step 6**		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	0
Step 2			**Step 7**		
2.1	10	10	7.1	10	10
Step 3			**Step 8**		
3.1	10	10	8.1	5	5
3.2	1	1	8.2	10	0
Step 4			8.3	1	1
4.1	5	5	8.4	1	1
4.2	1	1	**Step 9**		
Step 5			9.1	5	5
5.1	5	5	9.2	1	1
5.2	10	10	9.3	5	5
5.3	5	5	9.4	1	0
Step 6			**Step 10**		
6.1	5	5	10.1	NA	NA
6.2	1	1			
6.3	1	1			

Project Score	**95**
Project Possible Score	**110**
Validation Findings	**86%**

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name	**Select Health**
Name of PIP	**POST DISCHARGE FOLLOW UP FOR MEMBERS WITH ASTHMA EXACERBATION**
Validation Period	2015
Review Performed	10/2016

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic selected based on research and analysis of enrollee care needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**NOT MET**	Study questions were not found in the documentation. Recommendation: Include study questions in documentation.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measures are related to health status and processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire relevant population included.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies asthma codes and members to be included.
6.2 Did the study design clearly specify the sources of data? **(1)**	**NOT MET**	Study design does not describe the sources of data. Recommendation: Include data sources (administrative data, claims, medical review, etc.).
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection conducted according to specific Asthma codes.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**NOT MET**	Data analysis plan not provided. Recommendation: Include a specific statement on the data analysis plan, including how often data will be analyzed.

Component / Standard (Total Points)	Score	Comments
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**NOT MET**	Staff with data access is not documented. Recommendation: Document staff, along with required qualifications, for all data access.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**PARTIALLY MET**	Several interventions are listed, but documentation did not report which barriers are addressed by each intervention. Recommendation: Include a Table that displays the interventions and the barrier to which that intervention is applicable. The documentation should reflect which intervention(s) address each barrier/opportunity.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**NA**	Data Analysis Plan not provided.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	The rates for both measures were reported, and whether or not they met the Goal. The numerator and denominator for the rates were not documented. Recommendation: Document the numerator and denominator at each measurement in addition to the rate.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements identified. Statistical significance testing is not necessary as all eligible enrollees are included in the rate.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation includes both qualitative and quantitative discussion of results.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology was similar across measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	There was an initial increase in rates, but the past two years have noted a decrease in the rates. Recommendation: Focus on specific barriers and related interventions to increase the rates and meet goal increase each year.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	There was no improvement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No samples utilized.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	There was no improvement.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

	Possible Score	Score		Possible Score	Score
Step 1			**Step 6**		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	0
1.3	1	1	6.6	5	0
Step 2			**Step 7**		
2.1	10	0	7.1	10	5
Step 3			**Step 8**		
3.1	10	10	8.1	NA	NA
3.2	1	1	8.2	10	5
Step 4			8.3	1	1
4.1	5	5	8.4	1	1
4.2	1	1	**Step 9**		
Step 5			9.1	5	5
5.1	NA	NA	9.2	1	0
5.2	NA	NA	9.3	NA	NA
5.3	NA	NA	9.4	NA	NA
Step 6			**Step 10**		
6.1	5	5	10.1	NA	NA
6.2	1	0			
6.3	1	1			

Project Score	**52**
Project Possible Score	**80**
Validation Findings	**65%**

AUDIT DESIGNATION
LOW CONFIDENCE IN REPORTED RESULTS

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name	**Select Health**
Name of PM	**ALL HEDIS MEASURES**
Reporting Year	2015
Review Performed	10/2016

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2015

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**NA**	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements. Plan contracts with Outcomes Health Information Solutions for medical record abstractions.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. This is verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	**Select Health of South Carolina**
Collection Date:	October 2016

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					*Policy 161.001, Policy and Procedure Program Management and Format Guidelines*, defines the process for establishing new policies and revising/reviewing all policies. Select Health reviews policies on an annual basis and revises as needed. Select Health's policies are specific to the South Carolina line of business. Corporate policies are produced by AmeriHealth Caritas Family of Companies and adhered to by Select Health of South Carolina. New personnel are presented with all existing policies and procedures as part of orientation. Department

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						supervisors track new or changed policy review confirmation for existing staff. Policies and procedures are available to all staff on a shared drive. Policies are organized in a consistent manner and reviewed annually.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						The organizational chart demonstrates appropriate staffing at all levels to guarantee the delivery of healthcare products and services required by Select Health's contract with SCDHHS. Very few vacant positions were noted.
1.1 *Administrator (CEO, COO, Executive Director);	X					Rebecca Engelman is the Market President for Select Health of South Carolina and has the responsibility to oversee day-to-day business activities of the plan.
1.2 Chief Financial Officer;	X					Sean Popson is the Chief Financial Officer/Director of Finance for Select Health. She reports to Sharon Duncan, VP of Corporate Finance.
1.3 * Contract Account Manager;	X					James King is the Contract Account Manager and is responsible for submitting all contract deliverables and responding to requests from SCDHHS.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Information Systems personnel;						Select Health has IT support in the Charleston office.
1.4.1 Claims and Encounter Manager/Administrator,	X					Claims are managed by AmeriHealth Caritas Family of Companies in Kentucky. Local provider services staff assist providers with any questions or issues involving claims.
1.4.2 Network Management Claims/Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Regional UM Director is Kathy McElheney and the Manager of UM Review is M. McDaniel. They are supported by 3 supervisors, multiple clinical reviewers, and non-clinical UM technicians. According to the *UM Program Description*, the Select Health regional senior medical director serves as the medical management coordinator for Select Health and is responsible for the development, implementation, and oversight of all aspects of the Select Health Integrated Utilization Management Program.
1.5.1 Pharmacy Director,	X					The Regional Pharmacy Director is Jay Messeroff. He is a licensed pharmacist in South Carolina.
1.5.2 Behavioral Health Coordinator,	X					Cheryl Stockford was recently hired to fill this position.
1.5.3 Utilization Review Staff,	X					Utilization management includes intake, prior authorization, concurrent, retrospective, and behavioral health authorization reviews. The regional clinical director oversees the Rapid Response Program. This program provides immediate assistance to members in the form of transportation, transition management, or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						intensive case management (to meet urgent needs).
1.5.4 *Case Management Staff,	X					Janis Power is the director of integrated care management and A. Kilburn-Conyers is the manager of integrated care management. Case management functions are located in Charleston, SC and include complex maternal child case management.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Director of Quality Management is Faleisha Jones, certified by the Council for Affordable Quality Healthcare (CPHQ). The Manager of Quality Management is A. Boling. The medical director is very involved in quality processes including data analysis, HEDIS measures, and provider outreach on quality initiatives.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Director of Network Operations is Phillip Fairchild and the Director of Provider Network Management is Peggy Vickery.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Kevin Vaughn serves as director of member services. He is supported by a manager and 4 supervisors to oversee customer service representatives and intake member appeals and grievances.
1.8.1 Member Services Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 *Medical Director;	X					Dr. Greg Barabell (pediatrician) is the chief medical officer for Select Health of South Carolina. Select Health has recently added psychologist Dr. Beardmore as the behavioral health medical director. Dr. Barabell reports to the Regional Senior Medical Director, Dr. William Burnham (Family Practice). Dr. Barabell sits on the Quality Assessment and Performance Improvement Committee and chairs the Credentialing and Quality of Clinical Care Committees.
1.10 *Compliance Officer;	X					The Compliance Officer is Deonys deCardenas, director of agency affairs/compliance. She reports directly to the corporate compliance officer.
1.11 * Interagency Liaison;	X					
1.12 Legal Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					*Policy HR 116.103, Employee Credentialing*, details the procedures for verifying employee licensure where the job requires such licensure. Job descriptions include minimum education experience requirements.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Select Health processes and pays 90% of clean claims within 15 business days of receipt and 99% of all clean claims are paid within 30 calendar

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						days of receipt. Select Health returns at least 99% of rejected claims to the provider with a reason code within 15 days of receipt.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Select Health receives files electronically - daily and monthly (depending upon source). Data received electronically is verified for accuracy by monitoring file contents and comparing data with historical data trends. Select Health's practices and supporting documentation provided within the ISCA collection demonstrate Select Health is able to adequately conduct electronic transactions in a manner to meet or exceed requirements of the contract.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Select Health's ISCA documentation indicates that the necessary systems and processes are in place to adequately collect, report, and process data required by the MCO contract.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Select Health frequently assesses the security of the systems used to fulfill the MCO contract. The assessment results summarized within the ISCA document collection indicate an overall secure operating environment showing AmeriHealth has a focus on data security. Examples of this focus on security include regular ethical hacking exercises, HIPAA security audits every two years, and a risk assessment completed in June of 2016.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Network and physical security best practices are used to secure Medicaid data. The appropriate measures are in place to log and monitor data security.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Select Health has implemented disaster recovery and business continuity plans for systems that service the *SCDHHS MCO Contract*. The plans are well-documented and incorporate a tiered recovery strategy for disaster recovery and business continuity. Select Health also performs annual disaster recovery and business continuity tests. The most recent results indicate the exercise(s) was completed successfully.
I D. Compliance/Program Integrity						
1. The MCO has policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					Select Health has a comprehensive Corporate Compliance Program. The Program Integrity description defines processes used to prevent, identify, and address issues related to fraud, waste, and abuse. Policies, procedures, and a Compliance-Privacy work plan are in place. The *Select Health Training Presentation* for providers and employees contained information on fraud, waste, abuse, and the False Claims Act. Onsite discussion confirms this is required training for providers. Participation is tracked. Employee training is required upon hire and then annually. A *Code of Conduct and Confidentiality* agreement are signed. The *Compliance Plan* and associated policies do not include the requirement for Select Health to confirm providers train staff on the Federal False Claims Act. *Recommendation: Include in the Compliance Plan or a policy that Select Health informs*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers about the responsibility to train staff on the Federal False Claims Act as required in SCDHHS Contract, Section 11.2.4.
2. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Compliance Committee was a subcommittee of the Quality Assessment and Performance Improvement Committee (QAPI). It is now a stand-alone committee. The Compliance committee tracks and responds to ongoing compliance-related activities. It addresses and responds to all issues regarding compliance with federal and state regulations, as well as specific Medicaid program rules and requirements. This committee oversees and addresses potential fraud, waste, and abuse concerns. This committee meets quarterly or at least 3 x year. A quorum is met when at least 50% of voting members are present with at least six voting members. Compliance Committee membership found in the *QAPI Program Description*, the committee charter, and the *Program Integrity Description* are not consistent. *Recommendation: Confirm that an accurate and consistent list of Compliance Committee members is found in documents containing a membership list.*
I E. Confidentiality						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					The *QAPI Program Description*, page 26, confirms that all Select Health employees, as well as external entities involved in QI activities, are required to sign a confidentiality statement. *Policy 168.101, Confidentiality*, states newly hired associates and board members must read and sign the *Confidentiality, Privacy and Security Agreement* on the first day of employment and/or participation in board activities. The compliance officer serves as the local privacy officer. The *Notice of Privacy Practices* is mailed to members with new enrollee materials.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in manner consistent with contractual requirements.		X				The *Credentials Program 2016* and *Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing*, define Select Health's requirements for provider credentialing and recredentialing. The *Credentials Program* (page 13) and *Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing*, (page 6) state the *Medicare Opt Out* report is verified by the Credentialing department for credentialing; however, this is not mentioned in the recredentialing sections. Onsite discussion confirmed the *Medicare Opt Out* report is verified at recredentialing as applicable. *Quality Improvement Plan: Update the Credentials Program 2016 and Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, to include that the Medicare Opt Out report is verified, as applicable, for recredentialing.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.		X				The *2016 QAPI Program Description* states the Credentialing Committee is responsible for reviewing practitioner and provider applications, credentials, and profiling data (as available) to determine appropriateness for participation in the plan's network. The Credentialing Committee reports to the QAPI Committee and meets at least monthly. Dr. Greg Barabell, market chief medical officer (CMO), chairs the Credentialing Committee and voting members include the regional CMO, four Select Health medical directors, and three network providers with the specialties of pediatrics and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						family practice. The committee chair votes only in place of a tie. A quorum is met with over 50% of the voting members in attendance and a review of committee meeting minutes shows the quorum was met. The following issues were identified: •Dr. David Soper is listed as a voting member on the Credentialing Committee list received in the desk materials. However, committee meeting minutes show that he has not been on the roster since December 2015. •Dr. Melissa Pearce, medical director, is a voting member of the committee yet she does not appear on the Credentialing Committee membership list. •The Credentialing Committee list shows Dr. Greg Barabell as the committee chair and that he is a voting member of the committee. However, committee meeting minutes indicate that he only votes in case of a tie. This is not documented in the Credentialing Committee list. It is also not documented in the *2016 QAPI Program Description* which indicates on page 17 that the committee chair has voting privileges. *Quality Improvement Plan: Update the Credentialing Committee list of members to reflect current members of the committee. Update the Credentialing Committee list of members and the 2016 QAPI Program Description to reflect the Credentialing Committee chair only votes in case of a tie.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files reviewed are organized and contained appropriate documentation.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS Certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
3.1.10 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.11 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
3.1.12 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.13 Ownership Disclosure form .	X					
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.	X					The *Credentials Program 2016* states an initial on-site visit is completed for each primary care physician (PCP) office during the initial credentialing process. If the health care professional has multiple sites, a separate site visit is completed for each practice site location. Site visits are also performed when a participating PCP physician opens a new office site. The manager or director of network management must indicate the acceptance of the site visit and that results fall within the accepted pass range prior to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Credentialing Committee presentation. *Policy NM 159.107, Site Visit*, establishes the guidelines regarding site visits for participating providers. Evidence of appropriate site visits was received in the credentialing files.
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files reviewed are organized and contained appropriate information. One recommendation is listed below.
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					All recredentialing files except one contained appropriate malpractice insurance information. One recredentialing file reviewed showed the malpractice insurance was expiring on 7/15/16 and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Credentialing Committee approval was received on 6/24/16. Select Health stated the malpractice insurance has to be active when the Credentialing Committee reviews the information. However, *Policy CR.100.SC* states that if a document will expire within 30 days of receipt, they will request an updated certificate. Select Health received the copy of the malpractice insurance information on 6/20/16 and the expiration date was 7/15/16. Updated information was not requested. *Recommendation: Confirm request for updated document/certificate is performed for credentialing/ recredentialing when the expiration date is within 30 days of receipt.*
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of Service System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); State Excluded Provider's Report;	X					
4.2.9 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 In good standing at the hospitals designated by the provider as the primary admitting facility. (hospital privileges/coverage plan);	X					
4.2.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.12 Ownership Disclosure form.	X					Requirements are defined in *Policy NM 159.205, Ownership Disclosure*. The forms are collected during credentialing and recredentialing. Annually, Select Health contacts the disclosing entity to verify that the information submitted on the *SCDHHS 1514* is still correct. If any information has changed, a new form is collected.
4.3 Site reassessment if the provider location has changed since the previous credentialing activity.	X					*Policy NM 159.108, Member Quality of Service Grievance Against a Provider/Practitioner*, defines the responsibility and process for responding, resolving and monitoring a member's grievance regarding a provider or practitioner's quality of service or office environment. The policy states that all grievances received by the plan for a provider regarding office environment issues will trigger a site visit within 45 calendar days of the date the grievance was received.
4.4 Review of practitioner profiling activities.	X					Provider performance reports are produced quarterly and include selected Healthcare Effectiveness Data and Information Set (HEDIS) quality performance measures. The reports compare providers against their own performance in the previous calendar year as well as to NCQA standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					*Policy QI 205.010, Review of Potential Quality of Care Concerns*, states it is the policy of the AmeriHealth Caritas to confidentially investigate, review and report potential quality of care concerns. The policy defines the procedures for identifying, investigating, evaluating, and reporting all clinical quality issues as appropriate. *Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality*, describes the purpose and process for conducting sanctioning activities and compliance with reporting requirements. This policy references *Policy 154.300, Review of Potential Quality of Care Cases*, which was not received in the desk materials. A copy of *Policy QM154.300* was received after the onsite visit in an AmeriHealth Caritas policy named, *Review of Potential Quality of Care Concerns* that is not specific to Select Health. *Recommendation: Update policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality, to reflect the correct reference for the Select Health policy, Review of Potential Quality of Care Concerns. The AmeriHealth policy QM 154.300 is not specific to the SC line of business.*
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The *Credentials Program 2016* and *Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process*, details the credentialing/ recredentialing process for organizational providers. However, the *Credentials*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program 2016 contains inconsistent information when compared to *Policy CR.103.SC*. Onsite discussion confirmed the information should be consistent. *Quality Improvement Plan: Update the Credentialing Program 2016 and/or policy CR.103.SC to reflect consistent information regarding organizational providers.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					The *Credentials Program 2016* and *Policy CR.104.SC, Ongoing Monitoring-Licensure and Medicare/Medicaid Sanctions*, define the process of monthly monitoring of licensure sanctions, Medicare/Medicaid sanctions, data bank activity, and potential quality of service issues. Select Health has a process to terminate participating status and communicate actions to the Credentialing Committee if it is determined that a provider is being precluded from Medicare/ Medicaid funding.
II B. Adequacy of the Provider Network						
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					*Policy NM 159.206, Availability of Practitioners*, states that family and general practice PCPs and pediatricians are measured "2 within 20 miles" for urban/suburban and internal medicine PCPs are measured "1 within 30 miles" for urban/suburban.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						OB/GYNs are measured "1 within 20 miles" for urban/suburban and rural areas are measured "1 within 30 miles" for all PCP specialties. According to the *2015 Geographic Accessibility Report*, Select Health achieved 100% compliance with the established standards for access to family/general practice, internal medicine, and pediatric PCPs. OB/GYN providers achieved 100% for urban/ suburban and 99.9% for rural.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.		X				*Policy NM 159.206, Availability of Practitioners*, states that specialty care providers are measured as "1 within 30 miles" for urban/suburban and "1 within 50 miles" for rural areas. Hospitals are measured as "1 within 50 miles". The *2015 Geographic Accessibility Report* shows, for the high/volume specialties, measurement results were 100% except for dermatology (88.7% rural) and nephrology (99.4%) rural. Interventions included continued efforts to negotiate with identified specialists, seek assistance from PCPs in identifying additional specialists, and recruit potential specialists in neighboring states. *Policy NM 159.304, Behavioral Health Provider/ Practitioner Geographic Access*, defines the geographic access standards for participating behavioral health providers as "1 within 50 miles". Behavioral health providers include psychologists, psychiatrists, and licensed professional counselors (which include licensed independent social workers, licensed marriage and family counselors and licensed psycho-educational therapists.) The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						goal is to have 95% of members statewide have access within the identified 50 mile requirement for required provider area. Provider-to-member ratios are also defined with onsite discussion confirming the ratios listed in the policy for psychiatrists and psychologists are incorrect. *Quality Improvement Plan: Update policy NM 159.304, Behavioral Health Provider/Practitioner Geographic Access, to reflect the correct provider-to-member ratios for psychiatrists and psychologists.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.		X				*Policies NM 159.206, Availability of Practitioners*, and *NM 150.304, Behavior Health Provider Availability*, state Select Health monitors the geographic availability annually and/or on an as needed basis to assess the sufficiency of the provider network. However, the *SCDHHS MCO Contract, Section 6.2.3.1.2*, requires network submission bi-annually. Onsite discussion confirmed that a formal assessment is conducted annually. GeoAccess reports are conducted bi-annually to meet contract requirements. *Quality Improvement Plan: Update policies NM 159.206, Availability of Practitioners, and NM 150.304, Behavior Health Provider Availability, to include GeoAccess reports are conducted bi-annually.*
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign	X					*Policy NM 159.101, Assessing the Cultural Responsiveness of the Provider Network*, defines the process for collecting and publishing key

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
language/cultural requirements, and complex medical needs.						demographic information on Select Health's network providers to enable members to choose practitioners who meet their cultural and linguistic needs. Race, ethnicity, and language data is collected from all contracted network providers. Office support staff languages are collected voluntarily through provider visits and the credentialing process. Annually, Select Health performs a review of the language needs for the plan's membership and provides an assessment of the network's ability to adequately meet the identified membership needs and preferences. Member materials are available in Spanish and language translation services are available to members 24 hours per day, seven days per week. In addition, alternate print formats are available for printed materials including large print and Braille.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.		X				Select Health maintains a website-based searchable *Provider Directory* and members can contact Member Services to request a printed copy of provider information. *Policy PNO 170.201, Provider Data Change/Update Policy for FACETS and Directories,* states that hours of operations and accreditation (if any) are listed in the paper and online provider directories. However, this information is not listed in the paper *Primary Care Directory* or the *Specialist & Ancillary Directory*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						received in the desk materials. *Quality Improvement Plan: Address the inconsistency of information between the paper provider directories and Policy PNO 170.201, Provider Data Change/Update Policy for FACETS and Directories.*
3. Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				*Policy NM 159.203, Accessibility of Services*, defines appointment scheduling requirements that comply with contract guidelines. On an annual basis, an after-hours survey is conducted for all PCP locations to assess the 24 hour accessibility standard. The study was conducted in May/June 2015 and results showed that out of 1007 calls to provider groups, 99.9% met the after-hours availability. Provider offices not meeting the standard were contacted and follow-up calls made to ensure compliance. "Routine" and "Urgent" care standards are measured via questions 6 and 4 on the annual CAHPS 5.0 Survey. "Emergencies" are measured by monitoring ongoing grievances. Results of the CAPHS survey for 2015 showed that getting needed care and getting care quickly (appointment access) had trended down from the previous year. Onsite discussion confirmed that Select Health is considering conducting an appointment access survey in 2017.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy NM 159.306, Accessibility of Behavioral Healthcare Services, defines the appointment access standards for behavioral healthcare. The standards are measured at least annually using a provider survey method. Evidence of the 2015 survey was received and results showed that providers met the access standards for urgent, routine, and post-discharge follow-up care. Only 77% of the behavioral health providers could meet the non-life threatening emergent care standard. Opportunities and barriers were addressed in the report with interventions. *Policy NM 159.306* states 7 business days for the standard, "post-hospital discharge follow-up." However, the measurement in the access survey and on page 24 of the *Provider Manual* states a 7 day timeframe. Page 5 of the *Member Handbook* incorrectly states 4-6 weeks for PCP "routine visits." The *SCDHHS Contract, Section 6.2.2.1.2* states a timeframe of 4 weeks. *Quality Improvement Plan: Address the inconsistency between documents regarding the timeframe for the "post-hospital discharge follow-up" standard. Correct the "routine visits" PCP appointment timeframe in the Member Handbook.* *Recommendation: Consider conducting a provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appointment access study to identify member access issues.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			The Telephone Provider Access Study, conducted by CCME, reflects that calls were successfully answered 39% of the time (111/283) by personnel at the correct practice. This translates to between 36.4% and 41.9% for the entire population using a 95% Confidence Interval. When compared to last year's results of 39%, this year's study remained unchanged. *Quality Improvement Plan: Regarding member's access to their providers, identify and address barriers in the update process such that having up-to-date contact information for members is not an issue.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					*Policy NM 159.102, Provider Orientation and Ongoing Training*, states that Select Health offers training though Account Executives to all Medicaid network providers and staff regarding requirements of the state contract and providing services to Medicaid members. The training is conducted within 30 calendar days of active status.
2. Initial provider education includes:						
2.1 MCO health care program goals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					*Policy PNO 170.205, Ongoing Provider Training*, states that provider training will be provided on an as-needed basis we well as through quarterly regional trainings, which are conducted throughout the state. *Policy NM 159.102, Provider Orientation and*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Ongoing Training, states that Account Executives conduct on-going training on an as-needed basis when identified through DHHS updates, Federal and State mandates, Select Health departmental requests, Quality (HEDIS), provider requests, and survey results. Training can be offered through site visits, in office visits, letters to providers, updates in the *Provider Manual*, newsletters or other mailings, or corrective action plans. All in office training sessions are documented and trends are monitored for additional training opportunities.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					*Policy QI 205.004, Preventive Health Guidelines*, states that Select Health implements evidence-based preventive health guidelines that are relevant to the member population. Guidelines are adopted from nationally recognized sources and/or with collaboration from board-certified practitioners from appropriate specialties who would use the guideline. Preventative health guidelines are reviewed yearly at the Quality of Clinical Care Committee (QCCC) meeting and the Quality Assessment and Performance Improvement (QAPI) meetings.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Updated guidelines are posted on the Select Health website and communicated via the provider newsletter and/or fax blast.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					Select Health does not have pre/post-natal or obstetric guidelines listed on the website. A memorandum received after the onsite visit shows that parental and post-natal care guidelines were presented to the Quality of Clinical Care Committee on 11/19/15. In addition, page 74 of the *Provider Manual* lists obstetrical guidelines which are not listed on the website. *Recommendation: Update the website to include pre/post-natal or obstetric guidelines adopted by Select Health.*
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					The *2015 QAPI Evaluation* states that for preventive healthcare services, the plan's clinical performance must be monitored. Several measures were tracked: Adult BMI Assessment (ABA), Weight Assessment & Counseling in Children (WCC), Breast

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Cancer Screening (BCS), Cervical Cancer Screening (CCS), Well Visits in the 1st 15 months of life (W15), Well Visits in the 3rd/4th/5th/6th years of life (W34), and Adolescent Well Visits (AWC). Plan wide compliance is measured at least annually using HEDIS specifications; results are reported to the QAPI Committee for review, action, and monitoring.
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					*Policy IHCM 210 S, Clinical Practice Guidelines*, states that Select implements evidence-based preventive and clinical practice guidelines that are relevant to the member population. Guidelines are adopted from nationally recognized sources and /or in collaboration with board certified practitioners from appropriate specialties who would use the guideline. The Medical Management department reviews and recommends clinical practice guidelines from nationally established sources that develop the guidelines with a sound scientific basis, using clinical literature and expert consensus. The QCCC, which includes Medicaid healthcare providers, reviews any newly-proposed clinical practice guidelines. The QCCC also reviews all previously-approved clinical practice guidelines every two years, or sooner, if the national guidelines change during the two-year period. Upon review and recommendation by QCCC, the guidelines are forwarded to the QAPI. If

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recommended, these guidelines are adopted by the Medical Management department and disseminated to staff and providers.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					*Policy IHCM 210 S, Clinical Practice Guidelines*, states that Select Health distributes the guidelines to the appropriate network practitioners by mail, fax, email, or website. Annually, providers are reminded of the availability of these guidelines through the Plan website and provider newsletter.
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					Selected clinical practice guidelines are measured on an annual basis by the Quality Management department using HEDIS scores for plan-wide practitioner compliance.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					*Policy QI 205.011, Monitoring Continuity and Coordination of Care*, defines the mechanisms for monitoring the delivery of care to members to assist in identifying problems with continuity and coordination of care. Monitoring occurs annually and includes activities such as medical record review, member complaint/grievance/ appeal/transfer data analysis, annual practitioner surveys for PCPs and specialists, quality of care events, discharge planning, and other activities defined in the policy.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					*Policy QI 2015-009, Medical Record Review*, defines the guidelines for monitoring the quality of practitioner medical records. The reviews are conducted annually in conjunction with the plan's annual Healthcare Effectiveness Data Information Set (HEDIS) survey. The policy defines the medical record standards that comply with contract guidelines.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					In 2016, Select Health conducted a chart audit to identify physical health/behavioral health coordination/collaboration. The overall goal was to have at least 60% of PCPs and 60% of behavioral health providers actively exchanging information to better integrate the mental and physical well-being of the population. Overall, the audit indicated that approximately 40-45% of members' PCPs had documentation in the chart that indicated knowledge/coordination with the member's behavioral health providers. Most providers complied with the audit. Opportunities for improvement and interventions were identified and many were identified as target improvement for the Behavioral Health Collaborative Workgroup. The plan's annual Medical Record Review was completed in May 2016. The review of medical records was completed in coordination with the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						plan's behavioral health exchange of information assessment. Results showed the goal of 90 percent was achieved. However, areas of opportunity were identified that included education to providers regarding the identified issues.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Member rights and responsibilities are defined in *Policy MEM 129.100, Member Rights and Responsibilities.* Members are educated about their rights and responsibilities upon enrollment via the mailed *Member Handbook*, the website, and telephonic new member orientation. Methods to obtain a copy of the rights and responsibilities are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						published annually in member newsletters.
2. Member rights include, but are not limited to, the right:	X					Member rights and responsibilities are appropriately documented in Policy *MEM 129.100, Member Rights and Responsibilities, the Member Handbook, the Provider Manual*, and on the Select Health website.
2.1 To be treated with respect and dignity;						
2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation;						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:	X					Within 14 calendar days of receipt of enrollment data, a packet of information is mailed to new members including the *Member Handbook*, *Co-Payment Reference Guide*, *Notice of Privacy Practices*, and *Quick Start Guide*. Changes made to the *Member Handbook* are documented in the *Member Handbook List of Changes* on the Select Health website.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The *Member Handbook* and *Provider Manual* document covered benefits and services. However, newborn hearing screenings are not addressed in the *Member Handbook*. ***Recommendation**: Include information on coverage of newborn hearing screenings in the Member Handbook.*
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						The *Member Handbook* discusses copayment requirements for members and defines members who are exempt from co-payments. Co-payment amounts are listed in the *Co-Payment Reference Guide*. Members are instructed to call Member Services for questions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The *Member Handbook*, page 23, includes a statement within the "Members' and Potential Members' Bill of Rights" section that emergency services do not require prior authorization. However, page 9 of the *Member Handbook* contains a section titled "Emergency and Urgent Care" which does not indicate emergency services require no prior authorization. ***Recommendation**: Update page 9 of the Member Handbook (Emergency and Urgent Care heading) to include emergency services require no prior authorization.*
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *Member Handbook* describes the process for obtain medications at pharmacies, informs of the monthly prescription limit for adults 21 and older, and defines the items for which limits do not apply.
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and						The *Member Handbook* informs that members will be notified by mail when their PCP is leaving the network and provided a new PCP in their area.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
providing assistance in obtaining alternate providers;						Members may choose a different PCP by calling Member Services within 30 days. Select Health coordinates continuity of care for members in an active treatment program with a provider whose contract has ended.
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.12 Procedures for disenrolling from the MCO;						
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						The *Member Handbook* contains brief information on the appeals and grievances processes and State Fair Hearings.
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The *Member Handbook* informs that the *Provider Directory* is available in paper or on the website and includes a list of participating providers along with address, phone number, specialty, and whether the provider is accepting new patients. Members may contact Member Services for more information about a provider or to request a directory.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The *Member Handbook* contains a table with important phone numbers including Member Services' toll free phone and TTY number. The mailing address is included in several locations in the *Member Handbook*, but no email address is found. The Select Health website contains a link for members to send secure email, but the availability of this is not mentioned in the *Member Handbook*. Onsite discussion confirmed the Member Handbook is currently being revised to include the availability of the website's secure email function.
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services						The *Member Handbook* defines EPSDT visits and includes the recommended schedule for visits based on age of the child. The Select Health "Well Care Center" webpage (http://www.selecthealthofsc.com/preventive-care/provider/awc/educate-members.aspx) is missing telephone numbers and links to obtain more information about EPSDT services. ***Recommendation**: Update the "Well Care Center" webpage with the telephone numbers and links to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						obtain more information about EPSDT services.
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can received assistance with executing an advance directive;						The *Member Handbook* defines an Advance Directive and members are instructed to call Member Services to find out how to make an Advance Directive. No other information is provided. However, onsite discussion and demonstration confirmed the *Member Handbook* is being revised to include more comprehensive information about Advance Directives.
1.22 The SCDHHS fraud hotline and fraud email address and toll-free line;						The *Member Handbook* contains First Choice's Fraud and Abuse Hotline number and mailing address, First Choice's Compliance Hotline number, and SCDHHS' Division of Program Integrity Fraud and Abuse Hotline number, email address, and mailing address. The *SCDHHS Contract, Section 11.2.9.1*, requires SCDHHS' fraud hotline, fraud email address, and toll-free line to be placed in a prominent position in all member communications so that members may easily identify the information in the materials. This information, located on pages 26-27 of the *Member Handbook*, is not displayed in a prominent location. ***Recommendation**: Ensure information on reporting fraud, waste, and abuse, appears in a prominent position in the Member Handbook.*
1.23 Additional information as required by the contract and by federal regulation.						The *SCDHHS Contract, Sections 3.9.1.25* and *3.9.1.26*, require the *Member Handbook* to include that a member should notify the plan of any Worker's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Compensation claim, pending personal injury or medical malpractice law suit, or auto accident, and that the member should notify the plan when they have or obtain another health insurance policy. Onsite discussion and demonstration confirmed Select Health has already identified these issues and is currently revising the *Member Handbook* to include the required information. The *SCDHHS Contract, Section 3.9.1.31*, requires the *Member Handbook* to inform members of additional information available upon request, including information on the structure and operation of Select Health, physician incentive plans, and service utilization policies. This information is not found in the *Member Handbook*. ***Recommendation***: *Add information required by the SCDHHS Contract, Section 3.9.1.31 to the Member Handbook.*
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.		X				*Policy MEM 129.117, Termination of Primary Care Provider*, and *Policy MEM 129.125, Termination of a Specialist or Hospital*, address requirements and processes for notifying members affected by provider's termination from the Select Health network. The *SCDHHS Policy & Procedure Guide, Appendix 1*, states members have the right to receive notice of any significant changes in the benefits package at least 30 days before the intended effective date of the change. However, no policy was submitted which

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addresses member notification of changes to services or benefits. Onsite discussion revealed members receive 30 days' written notice when there is a change to services or benefits. ***Quality Improvement Plan**: Include in a policy the requirements and process for notifying members of changes to services and/or benefits.*
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Desk materials did not include a policy that addressed reading level requirements for member materials. However, onsite discussion revealed Select Health is currently revising and consolidating policies to incorporate changes in the upcoming contract. Onsite discussion confirmed the reading level of member materials is 6.9 using the Flesch-Kincaid testing method. Member materials are available in English and Spanish. Alternate formats available include, but are not limited to, other languages, Braille, large font, audio tapes, VHS with Closed Captioning, and oral interpretation of information for which written translation is not readily available.
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					The *Member Handbook* contains the toll-free telephone number and hours of operation for the Member Services Department and the Nurse Help Line. Policies are in place to ensure availability of Member Services staff, to make 24-hour coverage available, and to define performance standards for the Member Services Department. Call center performance data is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reported to the Quality of Service Committee and the Quality Assessment and Performance Improvement Committee (QAPI). To maintain service standard compliance, staff in other Member Services roles are cross-trained to assist the call center staff in times of high call volume. Processes are in place for back-up coverage for the call center in unusual situations, such as closures due to inclement weather, etc.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Within 14 calendar days of enrollment, Member Services staff attempt to contact all new members to conduct new member orientation and verify the member has selected a PCP. If unable to contact the member, a PCP is assigned to the member using a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						systematic algorithm. Information in the new member packet encourages the member to contact Member Services to select a PCP.
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					The *First Choice Quick Start Guide* contains recommended adult and child preventive health services along with their recommended schedule. Discrepancies were noted in the Disease Management programs in various documents. The *Member Handbook* lists the Breathe Easy Program, the Bright Start Program, and the In Control Program, but does not include the Heart First or Sickle Cell Programs which are listed in the *Provider Manual*. The Make Every Calorie Count Program is included in the *Case Management Program Description* but not listed in the *Member Handbook* or *Provider Manual*. ***Recommendation**: Update the Member Handbook and Provider Manual to include all Disease Management Programs available to members.*
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					*Policy QI 205.006, EPSDT/Prevention and Screening Outreach*, defines EPSDT requirements and includes the contractually required components of EPSDT exams.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Select Health reminds eligible members of the recommended services according to the EPSDT Periodicity Table and/or the Preventive Health Guidelines, and advises members of the need to schedule appointments for EPSDT screenings.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Quarterly newsletters include information about health risk factors and wellness promotion.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					Select Health contracts with Morpace, a certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, to conduct both the adult and child member satisfaction surveys. Survey response rates were 23% (Child) and 20% (Adult). These rates are lower than the 2014 rates of 29% for adult and 30% for children. ***Recommendation**: Continue working with vendors to increase response rates for the Child and Adult member satisfaction surveys. Possible ideas to increase response rates include offering incentives, announcing the survey in bulletins and on websites, and adding a reminder to call center scripts. Decide upon an internal goal to increase response rates (such as a 3% increase each year).*
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Morpace summarizes and details all results from the member satisfaction survey.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					*Quality of Clinical Care Committee Minutes (March 2016), the UM Annual Evaluation,* and *DNU 2016 CAHPS®* analysis documents provide evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction. The Quality of Clinical Care Committee, Utilization Management Department, and the Quality Assessment Performance Improvement Committee were involved in generating interventions and initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The Select News March 2016 newsletter reported a summary of the CAHPS® member satisfaction results to providers.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were	X					Several meeting minutes include discussion of satisfaction results and interventions to address barriers/gather accurate data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
identified.						
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					*Policy MEM 129.101, Member Grievances and Appeals Process*, describes the processes followed for receipt, investigation, and resolution of member grievances.
1.1 Definition of a grievance and who may file a grievance;	X					The definition of a grievance and information on who may file a grievance are appropriately documented in *Policy MEM 129.101, Member Grievances and Appeals Process*, the *Member Handbook*, and the *Provider Manual*.
1.2 The procedure for filing and handling a grievance;	X					Procedures for filing and handling grievances are correctly documented in *Policy MEM 129.101, Member Grievances and Appeals Process*, the *Member Handbook*, and the *Provider Manual*.
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				Timeliness requirements for grievance resolution and extensions are appropriately documented in *Policy MEM 129.101, Member Grievances and Appeals Process*, the *Member Handbook*, and the *Grievance Acknowledgement Letter*. The *Provider Manual* does not define the timeframe for grievance resolution but provides information on extensions of grievance resolution timeframes. Page 46 states Select Health is required to investigate grievances (not related to the physical condition of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the office) and respond to the member within 5 business days. ***Quality Improvement Plan:*** *Include the grievance resolution timeframe in the Provider Manual.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					*Policy MEM 129.101, Member Grievances and Appeals Process*, appropriately defines the requirements for grievances reviewers.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Select Health retains grievance logs for 7 years or until the completion of any litigation, claim negotiation, audit, or other action involving the documents or records.
2. The MCO applies the grievance policy and procedure as formulated.		X				Several grievance files reflected resolutions and notifications which were not compliant with the 90-day requirement found in the *SCDHHS Contract, Amendment Two, Section 9.1.6.1.1,* and *Policy MEM 129.101, Member Grievances and Appeals Process.* One grievance file containing a possible clinical issue did not appear to be reviewed by an appropriate reviewer as required by *Policy MEM 129.101, Member Grievances and Appeals Process.* In addition, this file reflected an inappropriate resolution that the member was financially liable for an emergency room visit at an out-of-network facility. The *SCDHHS Contract, Section 4.6.9,* states, "The CONTRACTOR must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the CONTRACTOR consistent with 42 CFR 438.114."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Confirm grievance resolutions and notifications are compliant with timeliness requirements specified in the SCDHHS Contract, Amendment Two, Section 9.1.6.1.1, and Policy MEM 129.101, Member Grievances and Appeals Process. Ensure that grievances involving possible clinical issues are reviewed by an appropriate reviewer and that resolutions are compliant with contract requirements.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Mid-year and annual summaries of member grievances are presented to the Quality of Service Committee. The mid-year summary reviews the most frequent grievance categories and provider trending. The annual summary contains an evaluation of grievance activity and identifies areas for additional review. In addition, the Director of Member Services tracks total grievances and appeals by category and by provider, and reports trends to the Administrative Appeals & Grievances Committee for review and recommendations.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					Staff determines if requests for PCP change are due to member convenience or dissatisfaction and the reason is documented for tracking and reporting purposes. If the request is due to dissatisfaction, the member is advised of their right to file a formal grievance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
3. The timeliness guideline for completing a member's request to change their PCP is consistent with contract requirements.	X					Members may change their PCP by calling Member Services or by using the member portal on the Select Health website. Requests are completed within 1 business day of submission.

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Select Health's *Quality Assessment and Performance Improvement 2016 Program Description* outlines the program in-place for measuring and improving the care and services received by members and their providers. The program description discusses the objectives and the goals for the program are included in the Quality Improvement work plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					The *Quality Assessment and Performance Improvement 2016 Program Description*, page 9, as part of the scope of work, the program description mentions the development, implementation, and adherence assessment of clinical, preventive, and behavioral health practice guidelines. Results are reported to providers through a *Provider Performance Report*.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Select Health has included this as one of their objectives listed in the *Quality Assessment and Performance Improvement 2016 Program Description*. The monitoring of over and underutilization is also included in the scope of work.
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Assessment Performance Improvement Committee oversees Select's Health's efforts to measure, manage and improve the quality of care and services delivered to plan members.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Select's Market President, Rebecca Engelman, chairs the Quality Assessment Performance Improvement Committee. Membership includes senior executives and directors, network providers, and staff from each area of the health plan.
3. The QI Committee meets at regular quarterly intervals.	X					The Quality Assessment Performance Improvement Committee meets bi-monthly and has defined a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						quorum of at least 50% of voting members in attendance.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					All of the HEDIS measures met the protocol guidelines and are considered fully compliant. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".			X			The following projects were validated: Comprehensive Diabetes Care, Chlamydia Screening, Post Discharge follow-Up for Members with Asthma, and Coordination of care: ER Follow-Up. One project (Comprehensive Diabetes Care) received a validation score within the *Confidence* level. Two projects received scores within the "Low Confidence" level and one was scored within the "Not Credible level". Some of the recommendations given during the previous EQR were not implemented. The form used to document the Chlamydia Screening, Post Discharge Follow-Up for Members with Asthma Exacerbation, and the Coordination of care: ER Follow-Up did not contain all the required elements. The four projects failed to meet the validation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						protocol requirements. Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Quality Improvement Plan: Correct the errors identified in the performance improvement projects.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Select Health has incorporated several quality measures into the PCP report cards. Network providers can also utilize Select Health's web portal to pull gaps in care reports on their assigned members.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, the QI program is evaluated to measure the effectiveness of all aspects of the program. The *Quality Assessment and Performance Improvement 2015 Program Evaluation* was presented in the desk materials for review.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *2016 Integrated Utilization Management Program Description* and multiple policies and procedures define the scope, functions, and processes Select Health employs to guide the provision of utilization services. The Integrated Utilization Management (UM) department at Select Health involves the planning, organizing, directing and monitoring of non-delegated physical and behavioral healthcare services. Utilization Management activities and results are reported to the Quality Clinical Care Committee (QCCC) and reflect monitoring activities stated in the Quality Improvement Program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The *SCDHHS Contract, Section 9.1.5.3.4,* states the period for expedited service authorizations may be extended by up to 14 calendar days. *Federal*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Regulation § 438.210 (d) (2) (ii), also states the timeframe may be extended up to 14 calendar days. The following document contains a different timeframe: •*Policy MEM 129.101, Member Grievances and Appeals,* states on page 5 that expedited authorization decision timeframes may be extended up to 2 calendar days. All other documents state the extension may be up to 14 calendar days. *Quality Improvement Plan: Update Policy MEM 129.101, Member Grievances and Appeals, to be consistent with other documentation and the MCO Contract regarding the extension of expedited service authorizations.*
1.5 consideration of new technology;	X					The *Integrated UM Program Description,* page 13, states any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the medical director or designee for a decision. *Policy UM.016S, Evaluation of New Technology*, addresses review by the medical director using FDA, Hayes, scientific evidence, and a variety of sources for guidance.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					*Policy UM.003S Standard and Urgent Prior Authorization*, mentions that providers may be recognized as a Preferred Provider and may be eligible for a simplified service authorization process that recognizes the provider's ability to manage care.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A detailed description of this program was not found in the *UM Integrated Program Description* or other document. *Recommendation: Include a description of Select Health's preferred provider program in a policy, and/or program description. Reference SCDHHS Contract, Section 8.4.2.7.*
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The regional senior medical director serves as the medical management coordinator, responsible for development, implementation, and oversight of all aspects of the UM program.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The *Select Health Integrated UM Program Description* is developed with the regional director of utilization management to ensure a written Integrated UM program is updated annually with approval from the QAPI Committee. The Integrated Utilization Management program evaluates medical necessity, access, appropriateness, and efficiency of service delivery through the following program components: intake, prior authorization, concurrent review, discharge planning, retrospective review, provider disputes and member appeals. The utilization management team coordinates emergent, urgent and elective healthcare services and provides transitional care service coordination.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					*Policy UM.008S, Clinical Criteria*, lists the criteria that have been approved for use when making medical necessity authorization decisions. Requests not meeting criteria are submitted to the medical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						director for review. Only a medical director or physician designee can issue a denial of authorization. Review of the approval files submitted by Select Health indicated appropriate criteria is used, including individual needs of the member. Decisions are made within timeliness standards and are promptly communicated to providers.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					The UM staff collect the minimum necessary information to ensure appropriate clinical decision making. Select Health uses Interqual, ASAM, and internal coverage policies to guide decisions.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					*Policy UM.312S, Hysterectomy and Family Planning*, correctly defines the requirements for and limitations on these services. Members and providers are informed in their respective handbooks and manuals. Information is also available on the Select Health website.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					*Policy UM.008S, Clinical Criteria*, states while applying UM criteria, all personnel must consider the individual member factors and characteristics of the local health delivery system. Factors considered include co-morbidities, age, complications, home environment or the ability of facilities to provide appropriate care.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					*The Integrated UM Program Description and Policy UM.708S, Inter-rater Reliability (IRR)*, states licensed clinical reviewers involved in medical necessity decisions are assessed quarterly for consistent application of review criteria (by random chart audits and inter-rater reliability testing). Medical directors are assessed twice a year. A benchmark of 90% is set and performance below this

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standard requires an action plan. In addition, medical directors meet quarterly to discuss the application of review criteria. Onsite discussion confirmed the most recent IRR testing resulted in 100% of staff meeting the benchmark.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.		X				*Policy MED (PA) 150.400, Pharmacy benefits and Management*, defines Select Health pharmacy benefits and include benefits, limits, quantities, generic medicine, over the counter, step therapy, and co-payments with exclusions. Four prescriptions monthly for adults over age 21 with an additional 3 prescriptions for members with specific diagnosis. For drugs requiring prior authorization, an emergency 5-day supply will be provided. Transitioning members can obtain medications for 60 days for prescriptions needing prior authorization. It also includes prescription fills for 90 days under certain circumstances. Select Health has a Pharmacy Lock-In program consistent with contract requirements. The *Member Handbook* does not include that members may obtain a 5-day emergency supply of medication when prior authorization is required. The *Provider Manual, Policy MED PA 150-400 Pharmacy Benefits and Management*, and onsite discussion confirmed that Select Health offers a 90-day supply of generic medicines used to treat specific

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conditions in order to improve compliance to medication regimes. This information is not found in the *Member Handbook*. *Quality Improvement Plan: Update the Member Handbook to include information regarding a 5-day emergency supply of medication and a possible 90-day fill under certain circumstances. Reference the SCDHHS Contract Section 4.7.3.*
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					*Policy UM.905S, Emergency Room Services,* includes: •the description of the prudent layperson; •no prior authorization needed; •any provider until stabilized; •coverage when an authorized representative, acting for the organization, authorized the provision of emergency services; •member is not liable for treatment of an emergency condition; •post stabilization services. The *First Choice Quick Start Guide* has a nice graphic that defines emergency and urgent care conditions, where to go for help, and phone numbers including 911 and the 24-hour Nurseline.
8. Utilization management standards/criteria are available to providers.	X					*Policy UM.008S, Clinical Criteria*, states medical necessity review criteria are reviewed and approved annually or more often when indicated prior to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						inclusion into the UM process. It also includes that criteria utilized by Select Health are available upon request to providers and members. Providers and members are made aware of the availability of review criteria and how to obtain clinical criteria in the *Provider Manual* and written UM determination letters. Upon request, Select Health personnel may fax or read criteria over phone. Authorization determination letters include the opportunity to provide additional information, view the case file, and get a copy of the criteria used to make the decision.
9. Utilization management decisions are made by appropriately trained reviewers.	X					*Policy UM.003S, Standard and Urgent Prior Authorization*, states prior authorization is performed by UM staff who are supported by licensed physicians. Licensed clinical reviewers make determinations based on UM medical necessity criteria. If the clinical reviewer is unable to approve, the case is referred to the medical director/designee for determination. *Policy UM.017S, Notice of Adverse Determination*, states any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. UM staff include RNs, licensed behavioral health clinicians, and UM technicians that perform intake functions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					The program evaluation for the *2015 Integrated Utilization Management Program* contains data on authorization decision timeliness. Select Health achieves 96.4-99.8% compliance to timeliness guidelines for urgent concurrent, concurrent, urgent pre-service, non-urgent pre-service, and retrospective determinations.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					*Policy UM.003S Standard and Urgent Prior Authorization*, states if there is not sufficient information to make a determination, the UM staff will request additional information in accordance with the procedure outlined *in Policy UM.010S Timeliness of UM Decisions*. Denial file review confirmed UM staff request additional information as needed and allows sufficient time to receive the information.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial file review confirmed Select Health utilizes appropriate physicians/psychologists and psychiatrists to make denial determinations.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Denial decisions were communicated promptly and letters provided the appeal process and how to request an appeal. Denial letter templates include the member's right to examine the case file, obtain the criteria used to make the determination and to submit evidence. Denial letters are mailed by US mail. *Policy UM.017S, Notice of Adverse Determinations*, states decisions

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						are communicated within 1 calendar day of the decision. Select Health offers providers an opportunity to discuss pending denial decisions prior to Select Health issuing the denial notification.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					*Policy MEM 129.101, Member Grievances and Appeals Process*, and *Policy MED 131.300, Member Appeals Process-Standard Pre and Post Service and Expedited Pre Service*, detail the process for member appeals. Updated versions of these policies were provided during the onsite visit.
1.1 The definitions of an action and an appeal and who may file an appeal;	X					The definitions of an action and an appeal are found in the following documents: •*Member Handbook* •*Provider Manual* •Select Health website. •*Policy MED 131.300, Member Appeals Process-Standard Pre and Post Service and Expedited Pre-Service* •*Policy MEM 129.101, Member Grievances and Appeal Process* Who may file an appeal is found in the following documents: •*Member Handbook* •Select Health website •*Policy MED 131.300, Member Appeals Process-Standard Pre and Post Service and Expedited Pre-Service* •*Policy MEM 129.101, Member Grievances and Appeal*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Process The *Provider Manual* states a member or a health care provider acting on behalf of the member and with the member's consent may file an appeal of an action. It does not include that an authorized representative may file an appeal. Reference *Amendment 2* of the *SCDHHS Contract, Section 9.1.1.3.2* *Recommendation: Include in the Provider Manual an "authorized representative" may also file an appeal on behalf of a member.*
1.2 The procedure for filing an appeal;		X				*The SCDHHS Contract, Amendment 2, Section 9.1.1.3.2,* states appeals may be filed orally or in writing and unless the request is for an expedited resolution, must follow an oral filing with a written, signed appeal. The *Provider Manual* states on page 33 that appeals must contain a written request, but later on the same page it correctly states that appeals filed orally must be followed by a written, signed request. *Policy MEM 129.101, Member Grievances and Appeals, pages 10-11,* state if the member does not follow up in writing within 30 calendar days of the oral appeal, the appeal will be closed. If the written request is received within 90 days from the denial notification a new appeal will be initiated. This conflicts with *Policy MED 131.300,* page 3, which states if the member does not follow with the written request within 30 calendar days from the oral filing the appeal may be dismissed. However, the next

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sentence states if the written request is received within the 90 days to file an appeal, the timeframe for resolution begins with the written confirmation. According to *SCDHHS Contract Section 9.1.4.4.1*, the timeframe for the appeal begins with the receipt of the member's initial notification, written or oral. *Policy MEM 129.101* is correct in saying that a new appeal will be initiated with the receipt of the written request. The *Member Handbook* does not inform members that the written appeal request must be received within 30 days of the oral filing. It also does not include that the member has the right to review the case file regarding the appeal at any time during the process as found in the *SCDHHS Contract, Section 9.1.4.4.3.* *Quality Improvement Plan: Remove the statement in the Provider Manual that appeals must contain a written request. Update the language in Policy MED 131.300, to align with Policy MEM 129.101 which states the appeal will be closed if written confirmation is not received within 30 calendar days from the oral request and if the written request is submitted timely (within 90 days of the notice), a new appeal will be initiated. Update the Member Handbook to include the timeframe within which members must follow an oral appeal with the written request.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Appeal file review confirms that Select Health utilizes appropriate practitioners with the clinical expertise required for reviewing appeals.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					An expedited appeal process is defined correctly in policies, manuals, handbooks, and the Select Health website.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					*Policies MEM 129.101, Member Grievances and Appeals Process, and MED 131.300, Member Appeal Process*, contain the correct timeframes for resolution and extensions of appeals. Select Health acknowledges member appeals within 1 business day and provider initiated appeals within 5 business days.
1.6 Written notice of the appeal resolution as required by the contract;		X				Appeal resolution letters are sent to members using certified mail. Letters include requirements for requesting a State Fair Hearing. The "Appeal Expedited Status Denied" letter template states Select Health will send the outcome of the review in writing within 5 days of the decision. However, *Policy MEM 129.101 Member Grievances and Appeals Process,* states standard resolution of appeals and notice to the affected parties is 30 days from the day the appeal was received. *Quality Improvement Plan: Update the "Appeal Expedited Status Denied" letter template with the correct timeframe for notice to the affected parties.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					The *Member Handbook* includes information on requesting continuation of benefits during the appeals process. This information is also included in written notices sent to members and providers. State Fair Hearing files reviewed indicate Select Health is following their policies in the handling of these requests.
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal file review confirmed Select Health follows their policies and procedures when handling appeals. Acknowledgement timeframes were met in all except 2 files. Decisions were made in a timely fashion. However, 2 resolution letters were dated beyond the timeframe for resolution. These were the only exceptions noted.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Per the *Integrated UM Program Description*, Select Health acknowledges the quality of care and services received by members is reflected in UM processes and data collected is used to identify opportunities to improve provider and member experiences, identify areas needing improvement, identify issues with member access to healthcare services, and address quality of care concerns. Action plans are developed to address identified variances. Performance results and action plan results are communicated to staff via individual sessions, team meetings and department communications and reported to the QAPIC.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO utilizes case management techniques to insure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					Multiple policies and the *2016 Care Management Program Description* include the processes employed to accomplish integrated and complex care management for members. *Policy IHCM. 201S, Integrated Health Care Management Standard of Practice*, explains the identification of special healthcare groups for Targeted Case Management. Select Health receives information through the Phoenix System about members enrolled in Targeted Case Management. Case Management file review demonstrated complete assessments conducted in a timely fashion, vigorous follow-up and defined goals. Select Health care managers are committed to working with members until goals are met.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Per *Policy QI 205.012, Over and Under Utilization Monitoring and Reporting*, Select Health collects, reviews, analyzes, and reports on utilization data. This policy lists the data analyzed for trends. All data is recorded in the *Annual UM Program Evaluation* and reported to the Quality of Clinical Care Committee and also reported in the annual *Quality Program Evaluation*.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Select Health delegates UM Services including pre-authorization, post-authorization, retrospective reviews, and Provider Call Center functions to NIA. Credentialing, recredentialing, ongoing monitoring, and decision making are delegated to: •Georgia Regents •Greenville Hospital System •Health Network Solutions •Mary Black HealthNetwork •Medical University of South Carolina •Memorial Health Partners •Regional Health Plus •Roper St. Francis •St. Francis Physician Services The *Credentialing Delegation Agreement* template and contract with NIA were reviewed and contain the necessary information. This includes activities delegated, reporting responsibilities, and actions that may be taken for sub-standard performance. *Policy CR.101.SC, Delegation of Credentialing and Recredentialing Activities*, defines the processes for delegated credentialing and recredentialing activities. The *Credentialing Delegation Agreement, Appendix A*, specifies the delegated activities and includes the credentialing criteria. *Exhibit B* lists the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC-specific credentialing requirements. *Policy 277.010, Delegation Oversight*, and *Policy CR.101.SC, Delegation of Credentialing and Recredentialing Activities*, defines the processes for pre-delegation assessment of delegate capabilities along with annual oversight of delegate performance. Once an annual assessment is conducted, the result is a written summary with recommendations for corrective actions for identified issues. In addition to the annual assessment, oversight is performed via routine delegate reporting.
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Evidence of annual oversight for credentialing delegates and NIA was provided. The documentation included audit tools and a summary of results. All delegates scored 100% on their most recent annual assessment.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 administering required immunizations;	X					*Policy QI 205.009, Medical Record Review*, describes the processes for annual medical record review (MRR). It is performed in conjunction with the plan's annual Healthcare Effectiveness Data Information Set (HEDIS) survey. Identified participating primary care physician offices included in the HEDIS survey are also assessed for MRR. Medical record review includes assessing documentation of the immunization record for children and adolescents (18 years and younger) as well as assessing documentation of preventative screening and services in accordance with Select Health practice guidelines.
1.2 performing EPSDTs/Well Care.	X					*Policy QI 205.006, EPSDT/Prevention and Screening Outreach*, describes Select Health's outreach and notification activities for EPSDT and preventive health screenings. These include, but are not limited to, "Now Due" post cards, automated message reminders, birthday post cards, and letters to adult members encouraging them to obtain recommended health services. Members considered high risk for complications related to influenza receive automated messaging on the flu vaccine.
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Errors identified during the previous external quality review in Select Health's Performance Improvement Projects were not corrected. ***Quality Improvement Plan**: Ensure that all deficiencies from the EQR are corrected and that the corrections are implemented.*